

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 03/14/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 504012		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/20/2019	
NAME OF PROVIDER OR SUPPLIER SMOKEY POINT BEHAVIORAL HOSPITAL				STREET ADDRESS, CITY, STATE, ZIP CODE 3955 156TH STREET NORTHEAST MARYSVILLE, WA 98271			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
B 000	INITIAL COMMENTS An unannounced Full Survey following Complaints was performed by federal contract surveyors from 2/18/19 - 2/20/19 at Smokey Point Behavioral Hospital. The census on the first day of the survey was 85; the sample of active patients was eight (8).			B 000			
B 103	<p>SPEC MEDICAL RECORD REQS FOR PSYCH HOSPITALS CFR(s): 482.61</p> <p>The medical records maintained by a psychiatric hospital must permit determination of the degree and intensity of the treatment provided to individuals who are furnished services in the institution.</p> <p>This Condition is not met as evidenced by: Based on observation, interviews, and record review the facility failed to provide full and individualized assessments, treatment plans and treatment for eight (8) of eight (8) active sample patients (A1, A2, A3, A4, A5, A6, A7, and A8). These deficiencies prevent patients from receiving adequate individualized active treatment and can lead to prolonged hospitalization, or premature discharge before the patient has had sufficient care and planning to maximize the likelihood of success after discharge.</p> <p>These deficiencies include:</p> <p>I. For seven (7) of eight (8) active sample patients (A1, A2, A3, A4, A6, A7, and A8), the Psychosocial Assessment completed after admission concludes with generic wording in the section titled "Recommendations and Conclusions (of Program Therapist Role)" rather than specific individualized roles the therapist</p>			B 103			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 03/14/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 504012	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/20/2019
NAME OF PROVIDER OR SUPPLIER SMOKEY POINT BEHAVIORAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 3955 156TH STREET NORTHEAST MARYSVILLE, WA 98271		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
B 103	<p>Continued From page 1</p> <p>would have with each patient. This failure to individualize the role of the therapist prevents the establishment of individualized patient goals and target interventions by the therapist on the treatment plans which would assist the patient in improving towards discharge.</p> <p>For three (3) of eight (8) patients (A3, A7, and A8), the narrative summary in the Psychosocial assessment lacked specifics regarding areas requiring attention for discharge planning and merely indicated discharge planning would take place. This failure can lead to delayed discharge planning, resulting in prolonged hospitalization. (Refer to B108).</p> <p>II. The History and Physical examination assessment included only three aspects of a screening neurological exam to be evaluated: Deep Tendon Reflexes (DTRs), Cranial Nerve Exam, and Gait. In four (4) of eight (8) active sample records (A1, A4, A6, and A8), DTRs were not examined. In eight (8) of eight (8) (A1, A2, A3, A4, A5, A6, A7, and A8), there was no mention of the other areas of examination which were routine parts of a screening neurological. Failure to perform an adequate screening neurological exam can lead to a failure to identify medical problems that cause or contribute to the patient's compromised mental state. (Refer to B109).</p> <p>III. The facility failed to assure that Master Treatment Plans (MTPs) and Updates to the MTPs documented all staff participation via signatures on the same dates for four (4) of eight (8) patients (A1, A2, A3, and A4). Failure to assure all staff participants sign the plans and updates at the time they are developed precludes the assurance that all participants are actually</p>	B 103			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 03/14/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 504012	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/20/2019
NAME OF PROVIDER OR SUPPLIER SMOKEY POINT BEHAVIORAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 3955 156TH STREET NORTHEAST MARYSVILLE, WA 98271		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
B 103	<p>Continued From page 2 present. (Refer to B118).</p> <p>IV. For eight (8) of eight (8) active sample patients (A1, A2, A3, A4, A5, A6, A7, and A8), the Master Treatment Plans (MTPs) failed to list measurable, observable, and individualized goals. Instead, plans had pre-printed generic goal statements that were repeated from one patient record to another, regardless of patient symptoms, age, ability to concentrate and interact. These failures prevent both the patients and the treating staff from having clear understandings as to what behavior is targeted, and how to measure progress in treatment. (Refer to B121).</p> <p>V. The facility failed to ensure that Master Treatment Plans (MTPs) contained individualized active treatment interventions to address specific psychiatric treatment needs of eight (8) of eight (8) active sample patients (A1, A2, A3, A4, A5, A6, A7, and A8). Specifically, MTPs failed to include active treatment interventions that were based on presenting psychiatric symptoms resulting in hospitalization. Instead, the interventions listed on the preprinted problem sheets were generic, routine discipline job duties, and did not consistently state a method of delivery, or a focus of treatment. These failures result in a lack of guidance for staff to provide coordinated and individualized active treatment, potentially delaying patient improvement and discharge from the hospital. (Refer to B122).</p> <p>VI. For four (4) of eight (8) active sample patients (A5, A6, A7, and A8), the treatment notes for groups repeatedly stated that patients failed to attend certain groups, but were provided with alternative treatments. However, further review of the records failed to identify alternative</p>	B 103			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 03/14/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 504012	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/20/2019
NAME OF PROVIDER OR SUPPLIER SMOKEY POINT BEHAVIORAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 3955 156TH STREET NORTHEAST MARYSVILLE, WA 98271		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
B 103	<p>Continued From page 3</p> <p>treatments offered to the patients as documented in the records. Failure to provide alternative treatments to patients who do not attend groups can lead to failure to progress towards discharge, and failure to revise treatment plans to evaluate better approaches to patient treatment. (Refer to B124).</p> <p>VII. For patients residing on the two large census units (Open Adult and Transitional Care Unit), there were inadequate numbers of treatment modalities and inadequate physical spaces in which to provide the groups available to patients. In addition, there were no individual treatment modalities available to patients. There were two to three therapy groups each day on each of these units, open to all patients on the units (with a census of 29 and 23 respectively the first day of the survey). These groups were optional and were held in the large open day area where many other unscheduled activities were taking place simultaneously at loud and distracting noise levels, preventing patients and group leaders from having effective sessions. In addition, for two active sample patients (A2 and A8), treatment plans did not include any specific group modalities for treatment and plans were not revised when patients were not participating in available groups. These failures to provide sufficient therapy options to patients can lead to prolonged hospitalization. (Refer to B125).</p> <p>VIII. The facility failed to ensure that social workers wrote progress notes that contained information which specifically addressed patient progress or lack of progress towards treatment goals and discharge planning with the frequency required for eight (8) of eight (8) active sample patients (A1, A2, A3, A4, A5, A6, A7, and A8). This failure impeded the treatment team's ability</p>	B 103			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 03/14/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 504012	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/20/2019
NAME OF PROVIDER OR SUPPLIER SMOKEY POINT BEHAVIORAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 3955 156TH STREET NORTHEAST MARYSVILLE, WA 98271		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
B 103	Continued From page 4 to assess or evaluate the patient's response to treatment and modify plans as needed. (Refer to B130).	B 103			
B 108	DEVELOPMENT OF ASSESSMENT/DIAGNOSTIC DATA CFR(s): 482.61(a)(4) The social service records, including reports of interviews with patients, family members, and others, must provide an assessment of home plans and family attitudes, and community resource contacts as well as a social history. This Standard is not met as evidenced by: Based on record review the facility failed to provide full and individualized social work assessments for eight of eight active sample patients (A1, A2, A3, A4, A5, A6, A7, and A8). For seven (7) of eight (8) the Psychosocial Assessment concluded with identical or almost identical generic wording in the section on the role of the Program Therapist. In addition, for three of eight patients the assessment also lacked any specifics regarding areas requiring attention for discharge planning, and merely indicated discharge planning would take place. This failure to individualize the role of the therapist prevents the establishment of individualized patient goals and target interventions by the therapist on the treatment plans which would assist the patient in improving towards discharge; the failure to identify areas of discharge planning can delay hospitalization. Findings include: Record Review 1. Four records reviewed: A1 (assessment dated 2/2/19), A2 (assessment dated 12/22/18), A4	B 108			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 03/14/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 504012	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/20/2019
NAME OF PROVIDER OR SUPPLIER SMOKEY POINT BEHAVIORAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 3955 156TH STREET NORTHEAST MARYSVILLE, WA 98271		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
B 108	<p>Continued From page 5</p> <p>(assessment date not noted), A6 (assessment dated 12/8/18), had identical generic wording for therapist's role in the section titled "Recommendations and Conclusions (of Program Therapist Role)." All four read:</p> <p>"Discuss symptoms and treatment interventions related to diagnosis to increase patient's understanding of medication and education recommendations.</p> <p>Encourage patient to attend groups to learn CBT/DBT [sic] thought processing techniques and coping/social skills to effectively manage relationships, feelings of fear, anger, hopelessness, helplessness and inability to trust others. Encourage patient to attend DBT/CBT [sic] mindfulness relaxation techniques to effectively manage stress, insomnia, hallucinations and paranoia."</p> <p>2. For another three (3) of eight (8) (A3, A7, and A8), the section titled "Recommendations and Conclusions (of Program Therapist Role)" had generic wording although not identical to the four noted above.</p> <p>a. In the section titled "Recommendations and Conclusions (of Program Therapist Role)," the record of Pt. A3 (assessment dated 1/23/19) stated: "meet with pt. 1-to-1 daily as needed & facilitate CBT/DBT groups 1 hr daily to help pt. identify 1-2 triggers & coping skills to current symptoms, ...encourage pt. to attend ...groups & teach psychoeducation groups weekly ..."</p> <p>b. In the section titled "Recommendations and Conclusions (of Program Therapist Role)," the record of Patient A7 (assessment dated 1/11/19) stated: "Provide individual & group</p>	B 108			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 03/14/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 504012	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/20/2019
NAME OF PROVIDER OR SUPPLIER SMOKEY POINT BEHAVIORAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 3955 156TH STREET NORTHEAST MARYSVILLE, WA 98271		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
B 108	Continued From page 6 psychotherapy. Provide psycho-education pertaining to the pt's stressors." c. In the section titled "Recommendations and Conclusions (of Program Therapist Role)," the record of Patient A8 (assessment dated 12/27/18) stated: "Meet 1:1 w/pt as needed. Facilitate CBT/DBT groups daily. Assist pt to identify triggers and coping skills." 3. Three active records reviewed: A5 (assessment dated 2/2/19), A7 (assessment dated 1/11/19), and A8 (assessment dated 12/27/18) had no identified areas requiring discharge planning in the Summary. a. A5's "Narrative Summary" stated: "shelter appears to be needed at discharge." There was no mention of follow-up services that would be arranged. b. A7's "Assessment of treatment and aftercare needs" stated, "Patient will more than likely follow up w/ [sic] JBLM after discharge for outpatient services." No description of what those services would be was provided. c. A8's "Recommendations and Conclusions (of Program Therapist Role)" stated, "Coordinate OP care prior to D/C."	B 108			
B 109	DEVELOPMENT OF ASSESSMENT/DIAGNOSTIC DATA CFR(s): 482.61(a)(5) When indicated, a complete neurological examination must be recorded at the time of the admission physical examination. This Standard is not met as evidenced by:	B 109			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 03/14/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 504012	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/20/2019
NAME OF PROVIDER OR SUPPLIER SMOKEY POINT BEHAVIORAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 3955 156TH STREET NORTHEAST MARYSVILLE, WA 98271		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
B 109	<p>Continued From page 7</p> <p>Based on record review and interview, the facility failed to have sufficient information in the History and Physicals (H&P) forms for eight of eight active sample patients (A1, A2, A3, A4, A5, A6, A7, A8). The History and Physical examination assessment form included only three aspects of a screening neurological exam to be evaluated: Deep Tendon Reflexes (DTRs), Cranial Nerve Exam, and Gait; there was no mention of the other areas of examination, which are routine parts of a screening neurological. Failure to perform an adequate screening neurological exam can lead to a failure to identify medical problems that cause or contribute to the patient's compromised mental state.</p> <p>Findings include:</p> <p>A. Record review</p> <p>1. DTRs not examined: In four (4) active sample records, DTRs were not examined (A1 exam dated 2/2/19; A4 exam date not noted; A6 exam dated 12/7/18; A8 exam dated 12/27/18). The checkmark next to DTR was blank, and a notation said, "N/A" [not applicable].</p> <p>2. Screening neurological not completed: In two (2) records, the screening neurological was not completed (A2 exam dated 12/21/18 and A5 exam dated 2/2/19).</p> <p>a. In the H&P for patient A2, the exam page noted, "in bed on R side - will not respond." All sections of the physical exam had notations of "pt. did not respond" or "no response."</p> <p>b. In the H&P of patient A5, the exam page noted "disheveled- mostly non-verbal slightly more receptive to Spanish" and sections of the exam</p>	B 109			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 03/14/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 504012	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/20/2019
NAME OF PROVIDER OR SUPPLIER SMOKEY POINT BEHAVIORAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 3955 156TH STREET NORTHEAST MARYSVILLE, WA 98271		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
B 109	Continued From page 8 had notations "refused" or "mostly refused." The only area marked as having been examined was Cranial nerves III, IV, and VI. 3. Incomplete areas of neurological screening listed: The H&P form listed only Gait (under "Musculoskeletal" exam), and DTRs and Cranial Nerves (under "Neurologic"). Therefore, none of the 8 active records had adequate screening neurological exams (A3-exam date not noted; A7- exam dated 1/10/19; all other exams were dated as noted above in sections 1 & 2.) B. Interview In an interview with the Medical Director on 2/19/19 at 12:30 p.m., he stated that the medical staff did peer reviews, but that there was no systematic review of any areas of medical staff involvement in patient care.	B 109			
B 116	PSYCHIATRIC EVALUATION CFR(s): 482.61(b)(6) Each patient must receive a psychiatric evaluation that must estimate intellectual functioning, memory functioning and orientation. This Standard is not met as evidenced by: Based on record review and interview, the facility failed to provide adequate documentation of memory functioning in the psychiatric evaluations for seven (7) of eight (8) active sample patient (A1, A2, A4, A5, A6, A7, and A8). This failure prevents the staff from having a documented baseline against which to evaluate patient progress or regression. Findings include:	B 116			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 03/14/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 504012	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/20/2019
NAME OF PROVIDER OR SUPPLIER SMOKEY POINT BEHAVIORAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 3955 156TH STREET NORTHEAST MARYSVILLE, WA 98271		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
B 116	<p>Continued From page 9</p> <p>A. Record Review</p> <p>In four (4) of the seven (7) records (A1, A2, A4, and A5), the section of the psychiatric evaluation titled "Memory" had two categories to check, one titled "Recent" and one titled "Remote." Next to each of these categories was a choice of two checkboxes, one titled "Intact" and one titled "Impaired." Next to the checkboxes was an open space to document "How tested." The examiner was to check a box in each category, whether intact or impaired, and then fill in how tested.</p> <p>In three (3) of the records (A6, A7, and A8), this form was not used. The following findings reflected the deficient evidence for each patient cited, date of evaluation in parentheses.</p> <p>1. Patient A1 (2/2/19): Both boxes "Intact" checked, no notation as to how tested.</p> <p>2. Patient A2 (12/21/18): Both boxes "Impaired" checked, notation said, "not able to assess."</p> <p>3. Patient A4 (date not noted): Both boxes "Intact" checked, notation said, "history questions."</p> <p>4. Patient A5 (2/2/19): Nothing checked. Notation said "nonverbal."</p> <p>5. Patient A6 (12/7/18): The form described above was not used. The documentation stated: "The patient's memory is intact both recent and remote. [S/he] can give a history."</p> <p>6. Patient A7 (1/10/19): The form described above was not used. The documentation stated: "Recent intact, tested during interview. Remote intact, tested by historical recall."</p>	B 116			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 03/14/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 504012	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/20/2019
NAME OF PROVIDER OR SUPPLIER SMOKEY POINT BEHAVIORAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 3955 156TH STREET NORTHEAST MARYSVILLE, WA 98271		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
B 116	Continued From page 10 7. Patient A8 (12/27/18): The form was not used. Documentation stated: "Rest of the mental status examination [which would include memory testing] cannot be completed since the patient is verbally not responsive at this time." B. Interview In an interview with the Medical Director on 2/19/19 at 12:30 p.m., he stated that the medical staff did peer reviews, but that there was no systematic review of any specific areas of medical staff involvement in patient care.	B 116			
B 118	TREATMENT PLAN CFR(s): 482.61(c)(1) Each patient must have an individual comprehensive treatment plan. This Standard is not met as evidenced by: Based on record review and interviews, the facility failed to assure that Master Treatment Plans (MTPs) and Updates to the MTPs documented all staff participation via signatures on the same dates for four (4) of eight (8) patients (A1, A2, A3, and A4). Failure to assure all staff participants sign the plans and updates at the time they are developed precludes the assurance that all participants are actually present. Findings include: A. Record Review: The MTPs had no dates on the form, and so dating could only be done by looking at the signature page prepared with the MTP. For updates, there was a space for a date, but often left blank, with signatures for the day of the	B 118			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 03/14/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 504012	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/20/2019
NAME OF PROVIDER OR SUPPLIER SMOKEY POINT BEHAVIORAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 3955 156TH STREET NORTHEAST MARYSVILLE, WA 98271		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
B 118	<p>Continued From page 11 update on the bottom of the page. Evidence documented for each patient follows:</p> <p>1. A1: An update (undated) was signed by two staff 2/6/19. The Psychiatrist (MD) and Activity Therapist (AT) signatures were undated.</p> <p>2. A2: An update (undated) was signed by two staff 2/7/19 and two staff (including the MD) on 2/8/19. Another update had a registered nurse (RN) signature dated 1/31/19, and an undated AT signature. No other signatures were present. A review dated 1/23/19 was signed by the MD and RN on 1/24/19; other signatures were dated 1/23/19. An undated review was signed by AT and social work (SW) on 1/18/19, and by the MD and RN on 1/21/19. There were three other updates with similar evidence.</p> <p>3. A3: All signature dates on the MTP were 1/23/19, except the MD which was 1/24/19. An update dated 1/27/19 was signed by the SW that date, and by all other disciplines on 1/29/19.</p> <p>4. A4: The MTP was signed by the SW 1/12/19, by the RN and AT on 1/13/19, and by the MD on 1/18/19.</p> <p>B. Interviews</p> <p>1. In an interview with the Medical Director on 2/19/19 at 12:30 p.m., he stated that the medical staff did peer reviews, but that there was no systematic review of any specific areas of medical staff involvement in patient care.</p> <p>2. In an interview on 2/20/19 at 1:00 p.m., the Acting Director of Social Work could not explain the discrepancies in signature dates.</p>	B 118			
B 119	TREATMENT PLAN	B 119			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 03/14/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 504012	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/20/2019
NAME OF PROVIDER OR SUPPLIER SMOKEY POINT BEHAVIORAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 3955 156TH STREET NORTHEAST MARYSVILLE, WA 98271		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
B 119	<p>Continued From page 12 CFR(s): 482.61(c)(1)</p> <p>The plan must be based on an inventory of the patient's strengths and disabilities.</p> <p>This Standard is not met as evidenced by: Based on record review and interview, the facility failed to ensure that Master Treatment Plans (MTPs) were based on an inventory of descriptive strengths and problem statements for eight (8) of eight (8) active sample patients (A1, A2, A3, A4, A5, A6, A7, and A8). Instead, strengths identified from the preprinted checklist were general statements and did not describe how the checked item reflected each patient's personal attributes that could be used to formulate treatment goals and active treatment interventions. In addition, the preprinted MTPs contained problems that were diagnostic terms or generalized psychiatric jargon rather than behaviorally descriptive psychiatric problems based on clinical assessment data and how each patient explicitly manifested symptoms or problems. The failure to identify patient strengths and behaviorally descriptive problems can adversely affect clinical decision-making in formulating MTPs and impairs the treatment team's ability to develop goals and results in treatment plans that are not individualized to patients' unique presenting psychiatric problems.</p> <p>Findings include:</p> <p>A. Record review</p> <p>1. Patient A1's MTP, signed 2/3/19, included the following deficient patient strength and psychiatric problem statements:</p>	B 119			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 03/14/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 504012	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/20/2019
NAME OF PROVIDER OR SUPPLIER SMOKEY POINT BEHAVIORAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 3955 156TH STREET NORTHEAST MARYSVILLE, WA 98271		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
B 119	<p>Continued From page 13</p> <p>Strengths: "Positive attitude and ability to communicate needs" These strength statements were very broad and failed to provide specific behavioral descriptions of the items checked to show they could be used to plan treatment goals and active treatment interventions. The MTP did not include the patient's personal attributes, skills, or accomplishments to be used in treatment.</p> <p>Problem Statement: "Reality Perception Impairment as Evidenced by: Disorganized and illogical thinking." This problem statement failed to include clear descriptive information about the patient's disorganized thinking and illogical thinking based on clinical assessments. The patient's psychiatric evaluation, dated 2/2/19, had provisional psychiatric diagnoses of "Psychosis due to Methamphetamine Use and Mood Disorder NOS [Not Otherwise Specified]." The psychiatric evaluation reported that before admission, the patient was " ... wandering for days then disturbing a business ... In ED [emergency department] [s/he] was endorsing AH/VH [auditory hallucinations/visual hallucinations] ... minimizes the effect if metham [Methamphetamine] use on perceptual thinking ... endorses increased sleep and fatigue."</p> <p>2. Patient A2's MTP, signed 12/21/18, included the following deficient patient strength and psychiatric problem statements:</p> <p>Strengths: "Able to identify Support System: Brother, previous good treatment response, and able to live independently." These failed to provide specific behavioral descriptions of the strength items checked to show they could be used to plan treatment goals and active treatment interventions. There was no information regarding the previous good treatment or the role the</p>	B 119			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 03/14/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 504012	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/20/2019
NAME OF PROVIDER OR SUPPLIER SMOKEY POINT BEHAVIORAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 3955 156TH STREET NORTHEAST MARYSVILLE, WA 98271		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
B 119	<p>Continued From page 14</p> <p>patient's brother would play in treatment. The MTP did not include the patient's specific personal attributes, skills, or accomplishments to be used in treatment.</p> <p>Problem Statement: "Reality Perception Impairment as Evidenced by: Schizoaffective Schizophrenia [sic]." This problem statement included a psychiatric diagnosis and failed to include clear descriptive information about the patient's impaired perceptions based on clinical assessments. The patient's psychiatric evaluation, dated 2/2/19, had a provisional psychiatric diagnosis of "Schizophrenia." The psychiatric evaluation reported that before admission, the patient was " ... delusional, disorganized ... [s/he] is not engaged ... lying in bed with covers to [his/her] chin ... [S/he] has not touch [sic] any meals / liquids ... has not been compliant with [his/her] meds [medications] ... Per family delusional thoughts worsen since off meds." [Note: There was no description of delusions in the psychiatric evaluation.]</p> <p>3. Patient A3's MTP, signed 1/23/19, included the following deficient patient strengths and psychiatric problem statements:</p> <p>Strengths: "Able to identify Support System: Parents, brother, friends. Stable financial resources: SS + disability, and Ability to communicate needs." These strength statements were very broad and failed to provide specific behavioral descriptions of the items checked to show they could be used to plan treatment goals and active treatment interventions. There was no information regarding any particular communication skills, or the role patient's parents, brother, and friends would play in treatment. The MTP did not include the patient's</p>	B 119			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 03/14/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 504012	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/20/2019
NAME OF PROVIDER OR SUPPLIER SMOKEY POINT BEHAVIORAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 3955 156TH STREET NORTHEAST MARYSVILLE, WA 98271		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
B 119	<p>Continued From page 15</p> <p>specific personal attributes, skills, or accomplishments to be used in treatment.</p> <p>Problem Statement: "Danger to self with Psychosis as evidenced by: Self-care deficit due to inability to care for self & medical needs during psychotic episode." This problem statement failed to include clear descriptive information about the patient's psychosis and inability to care for self as identified in clinical assessments. The patient's psychiatric evaluation, dated 1/22/19, had a provisional psychiatric diagnosis of "Schizoaffective Disorder." The psychiatric evaluation reported that before admission, the patient was " ... lying in a catatonic position at [his/her] home with ruptured ostomy bag covered in feces ... reported that [s/he] does take [his/her] medications ... not giving detailed information about, if [s/he] had stopped taking medications."</p> <p>4. Patient A4's MTP, signed 1/13/19, included the following deficient patient strengths and psychiatric problem statements:</p> <p>Strengths: "Stable Housing: Mother, Step-dad, siblings, and Ability to communicate needs." These strength statements failed to provide specific behavioral descriptions of the items checked to show they could be used to plan treatment goals and active treatment interventions. The stepfather was included as a strength despite evidence in problem statement regarding the patient's aggressive behavior toward the stepfather. There was no information regarding the specific communication skills, or the role patient's family members would play in treatment during his/her hospitalization. The MTP did not include the patient's specific personal attributes, skills, or accomplishments to be used in treatment.</p>	B 119			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 03/14/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 504012	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/20/2019
NAME OF PROVIDER OR SUPPLIER SMOKEY POINT BEHAVIORAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 3955 156TH STREET NORTHEAST MARYSVILLE, WA 98271		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
B 119	<p>Continued From page 16</p> <p>Problem Statement: "Danger to Other (sic) as evidenced by: Aggressive bx [behavior] toward step-father." This problem statement failed to include clear descriptions regarding the patient's aggressive behavior and particular psychotic symptoms based on clinical assessments. The patient's psychiatric evaluation, dated 1/12/19, had provisional psychiatric diagnoses of "Post Traumatic Stress and Psychosis NOS." The psychiatric evaluation reported that before admission, the patient was " ... admitted ... for assault and HI [homicidal ideations] toward stepfather ... had flashback of father being physically, [illegible] sexually abusing him/her in the past ... stabbed self with pencil 4 days ago ... [S/he] has AH [auditory hallucinations] commanding to harm self or others, or insult others ..."</p> <p>5. Patient A5's MTP, signed 2/15/19, included the following deficient patient strengths and psychiatric problem statements:</p> <p>Strengths: There were no strengths checked from the preprint list of strengths in the MTP. The MTP did not include the patient's specific personal attributes, skills, or accomplishments to be used in treatment.</p> <p>Problem Statement: "Danger to self with Psychosis as evidenced by: Pt. [Patient] having a plan for suicide and responding to internal stimuli." This problem statement failed to include descriptive information about the patient's psychotic symptoms, suicidal plan or his/her specific psychotic symptoms that included the content and behavioral effects of the internal stimuli. The patient's psychiatric evaluation, dated 2/2/19, had provisional psychiatric diagnoses of</p>	B 119			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 03/14/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 504012	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/20/2019
NAME OF PROVIDER OR SUPPLIER SMOKEY POINT BEHAVIORAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 3955 156TH STREET NORTHEAST MARYSVILLE, WA 98271		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
B 119	<p>Continued From page 17</p> <p>"Psychosis NOS and Mood Disorder NOS." The psychiatric evaluation reported that before admission, the patient was " ... reportedly found outside in cold weather at risk of hypothermia ... nonverbal in ED despite use of a Spanish language interpreter ... [S/he] did endorse SI [sic] plan to go to the mountains & freeze to death."</p> <p>6. Patient A6's MTP, signed 12/8/18, included the following deficient patient strength and psychiatric problem statements:</p> <p>Strengths: "Able to identify Support System: Family, Outpatient services established in the community, Ability to communicate needs, and able to live independently." These failed to provide specific behavioral descriptions of the strength items checked to show they could be used to plan treatment goals and active treatment interventions. There was no information regarding the role patient's family would play in treatment and specific communication skills. Having outpatient services was not a personal attribute that could be used to formulate treatment interventions during hospitalization. The MTP did not include the patient's specific personal attributes, skills, or accomplishments to be used in treatment.</p> <p>Problem Statement: "Reality Perception Impairment as Evidenced by: Psychosis." This problem statement included a psychiatric diagnosis and failed to include clear descriptive information about the patient's impaired perceptions based on clinical assessments. The patient's psychiatric evaluation, dated 12/09/19, had provisional psychiatric diagnoses of "Major Depression, recurrent, moderate, Polysubstance dependence, Borderline personality." The psychiatric evaluation reported, " ... a history of</p>	B 119			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 03/14/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 504012	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/20/2019
NAME OF PROVIDER OR SUPPLIER SMOKEY POINT BEHAVIORAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 3955 156TH STREET NORTHEAST MARYSVILLE, WA 98271		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
B 119	<p>Continued From page 18</p> <p>borderline personality disorder, ADHD [Attention-Deficit Hyperactivity Disorder, mood disorder NOS, polysubstance dependence, who presents ... on a voluntary basis. The patient states [s/he] did not feel ... medications were working ... decided to use amphetamine instead ... [S/he] was anxious and depressed."</p> <p>7. Patient A7's MTP, signed 1/11/19, included the following deficient patient strength and psychiatric problem statements:</p> <p>Strengths: "Stable Housing: [illegible], Stable financial resources: Navy, Adequate financial resources, Positive attitude, able to communicate needs, and able to live independently." These strength statements failed to provide specific behavioral descriptions of the strength items checked to show they could be used to plan treatment goals and active treatment interventions. Having outpatient services and financial resources were not personal attributes that could be used to formulate treatment interventions during hospitalization. The MTP did not include the patient's specific personal attributes, skills, or accomplishments to be used in treatment.</p> <p>There was no information regarding the patient's specific communication skills. The MTP did not include the patient's specific personal attributes, skills, or accomplishments such as the patient's college education that could be used in treatment while hospitalized.</p> <p>Problem Statement: "Depressed Mood." This problem statement included a psychiatric diagnosis and failed to include descriptive information about the patient's depressed mood based on clinical assessments. The patient's psychiatric evaluation, dated 1/11/19, had a</p>	B 119			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 03/14/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 504012	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/20/2019
NAME OF PROVIDER OR SUPPLIER SMOKEY POINT BEHAVIORAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 3955 156TH STREET NORTHEAST MARYSVILLE, WA 98271		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
B 119	<p>Continued From page 19</p> <p>provisional psychiatric diagnosis of "Alcohol Use Disorder, severe." There was no diagnosis related to mental illness. The psychiatric evaluation reported the chief complaint as "Alcohol detoxification and rehabilitation ... denies any psychiatric history ... recollects alcohol consumption began around age 16 ... recollects drinking on weekends ... at age 24 enlisted in United States Navy ... reported escalating [his/her] alcohol consumption ... increasing discord with [his/her] commanding officer ..." No information in the psychiatric evaluation substantiated the problem of Depressed Mood identified in the MTP.</p> <p>8. Patient A8's MTP, signed 12/28/18, included the following deficient patient strength and psychiatric problem statements:</p> <p>Strengths: "Able to identify Support System: Sister and able to communicate needs." These strength statements failed to provide specific behavioral descriptions of the strength items checked to show they could be used to plan treatment goals and active treatment interventions. There was no information regarding the role patient's sister would play in treatment or the patient's specific communication skills. The MTP did not include the patient's specific personal attributes, skills, or accomplishments that could be used in treatment while hospitalized.</p> <p>Problem Statement: "Depressed Mood." This problem statement included a psychiatric diagnosis and failed to include descriptive information about the patient's depressed mood based on clinical assessments. The patient's psychiatric evaluation, dated 12/28/18, had a provisional psychiatric diagnosis of "Bipolar disorder type1, most recent episode manic with</p>	B 119			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 03/14/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 504012	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/20/2019
NAME OF PROVIDER OR SUPPLIER SMOKEY POINT BEHAVIORAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 3955 156TH STREET NORTHEAST MARYSVILLE, WA 98271		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
B 119	Continued From page 20 psychotic features." The psychiatric evaluation reported ... The patient had unexpectedly jumped out of the car and left the house without shoes ... has increased mood lability ... very poor hygiene ... not sleeping for days and not taking any medications ..." B. Interviews 1. In an interview on 2/19/19 at 11:37 a.m., RN2 acknowledged that the strengths statements did not include personal attributes of the patient and that problem statements were not descriptive of each patient's presenting symptoms. RN2 stated that at the time of admission, the nurse selected the problem sheets for the treatment plans. 2. In an interview on 2/20/19 at 9:55 a.m. with the Director of Nursing, the MTPs were discussed. She agreed that problem statements were not descriptive of what brought the patient to the hospital.	B 119			
B 121	TREATMENT PLAN CFR(s): 482.61(c)(1)(ii) The written plan must include short-term and long range goals. This Standard is not met as evidenced by: Based on record review, the facility failed to provide measurable patient goals on the Master Treatment Plans (MTPs) for eight (8) of eight (8) active sample patients (A1, A2, A3, A4, A5, A6, A7, and A8). Each Problem statement usually was addressed on a single page, with preprinted goals which were generalized statements, and which were not measurable. Other goals listed were staff goals for the patient to achieve rather than patient goals. These failures prevent the	B 121			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 03/14/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 504012	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/20/2019
NAME OF PROVIDER OR SUPPLIER SMOKEY POINT BEHAVIORAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 3955 156TH STREET NORTHEAST MARYSVILLE, WA 98271		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
B 121	<p>Continued From page 21</p> <p>patient and the staff from having a clear understanding of what goals have been agreed upon, and how movement towards achieving them would be determined.</p> <p>Findings include:</p> <p>A. Record Review</p> <p>1. A1 (MTP signed 2/3/19): for the problem "disorganized and illogical thinking," the first goal was "Pt. will demonstrate or verbalize decreased psychotic symptoms, feelings of anxiety, agitation and improved reality perception"[vague and unmeasurable]. Other goals for this problem were similarly generic. For the problem "Substance Related Disorder," the only goal was "Pt. will participate in CD treatment."</p> <p>2. A2 (MTP signed 12/21/18): for the psychiatric problem "Reality Perception Impairment," the first two goals listed were "Pt. will take medications as prescribed" [a generic staff goal]; and "Pt. to report decrease paranoia by self-report" [unmeasurable]. For the psychiatric problem "anxiety" no goals were developed. For the medical problem of "gastritis, PUD [sic], dyspepsia, GERD [sic] as evidenced by [left blank]" the first goal was "Pt. will verbalize understanding of the diagnosis, treatment and management of [left blank]." The second goal was "Pt. will have relief of symptoms."</p> <p>3. A3 (MTP signed 1/23/19 and 1/24/19): for the psychiatric problem "Danger to Self with Psychosis," the first goal was "Patient will demonstrate use of the following coping skill (s) when having thoughts of losing control of emotions - "movies" "video games." [There was no evidence either of these was available to the</p>	B 121			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 03/14/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 504012	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/20/2019
NAME OF PROVIDER OR SUPPLIER SMOKEY POINT BEHAVIORAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 3955 156TH STREET NORTHEAST MARYSVILLE, WA 98271		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
B 121	<p>Continued From page 22</p> <p>patient, and how they would be used to cope with psychosis.] The second goal was "Pt. will take medications as prescribed [staff goal]." "[Pt.] will state s/he is feeling more calm and has an improved mood to staff." For the psychiatric problem of "Anxiety," the first goal stated was "Pt. will verbalize increased feelings of anxiety to staff [sic]." For the Problem of "Substance Related Disorder," the preprinted goal was exactly the same as for Patient A1: "Pt. will participate in CD treatment." For the medical problem of "Thyroid Function, Impaired," the first goal was almost the same as for the different medical problem of Patient A2: "The patient will verbalize understanding of the diagnosis, treatment and complications of the diagnosis."</p> <p>4. A4: (MTP signed 1/12/19, 1/13/19, and 1/18/19): for the psychiatric problem of "Danger to others as evidenced by aggressive bx [sic] toward stepfather," the goal was "Patient will identify the following warning signs of aggressive/assaultive behaviors: [left blank]." Another goal was "Patient will identify 1 coping skill to use when aggression increases resulting in aggression." For the problem "Substance Use Disorder," the only (preprinted) goal was identical to the goal for Patients A1 and A3: "Pt. will participate in CD treatment." For the problem of "Anxiety," the preprinted goals were identical to those for Patient A3: "Pt. will verbalize increased feelings of anxiety to staff [sic]." For the medical problem of "Asthma," the preprinted goal was almost identical to the goals for Patients A2 and A3, with very different medical problems; "Pt. will verbalize understanding of the disease process, common precipitants and the management plan."</p> <p>5. A5: (MTP signed 2/15/19): for the psychiatric problem of "Depressed Mood," the first goal was</p>	B 121			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 03/14/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 504012	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/20/2019
NAME OF PROVIDER OR SUPPLIER SMOKEY POINT BEHAVIORAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 3955 156TH STREET NORTHEAST MARYSVILLE, WA 98271		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
B 121	<p>Continued From page 23</p> <p>"[pt.] will willingly take medication prescribed for depression [staff goal]." Another goal was "[pt.] will participate in groups and attend 3 out of 6 groups offered each day." (This patient primarily communicated in Spanish. There was no mention of an interpreter in the plan.) For the problem of "Anxiety," see the identical pre-printed goal statements noted above for Patients A3 and A4.</p> <p>6. A6 (MTP signed 12/8/18): for the psychiatric problem of "Reality Perception Impairment," a goal was "Pt. will attend & focus in grp 50% x [sic]." For the problem of "Substance Related Disorder," the preprinted goal was identical to that of the other patients noted above with the same problem: "Pt. will participate in CD treatment." For the problem of "Anxiety," the first handwritten goal was "Pt. will identify one to two coping skills R/T [sic] anxiety such as state [his/her] willingness to use when [three illegible words] Identical [sic]." For the medical problem of "gastritis, PUD [sic], dyspepsia, GERD [sic] as evidenced by [left blank]," the preprinted goals were identical to those for Patient A2: The first goal was "Pt. will verbalize understanding of the diagnosis, treatment and management of [left blank]." The second goal was "Pt. will have relief of symptoms."</p> <p>7. A7 (MTP signed 1/11/19): For the problem of "Substance Related Disorder," the preprinted goal was identical to that for the patients noted above with the same problem: "Pt. will participate in CD treatment." For the problem of "Anxiety," the handwritten goal was "Pt. will identify one to two coping skills R/T [sic] anxiety."</p> <p>8. A8 (MTP signed 12/28/18): For the problem "Anxiety," the preprinted goals were identical to those patients noted above with the problem of</p>	B 121			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 03/14/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 504012	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/20/2019
NAME OF PROVIDER OR SUPPLIER SMOKEY POINT BEHAVIORAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 3955 156TH STREET NORTHEAST MARYSVILLE, WA 98271		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
B 121	Continued From page 24 Anxiety. No individualized parts were added to the generalized, preprinted statements. For the problem "Danger to Others with Psychosis," a Recreational Therapy goal (preprinted, and found in most MTPs) was "Pt. will demonstrate/ID 1-2 activities to engage in to use as coping skills." No focus for these skills was stated. Another preprinted goal was "Patient will identify 1 source of stress that leads to aggressive behaviors of [left blank.]" For the medical problem of "Insomnia," a preprinted goal was "Pt. will verbalize understanding of insomnia, treatment and safety measure [sic] related to compromised sleep patterns."	B 121			
B 122	TREATMENT PLAN CFR(s): 482.61(c)(1)(iii) The written plan must include the specific treatment modalities utilized. This Standard is not met as evidenced by: Based on record review, policy review, and interview, the facility failed to ensure that Master Treatment Plans (MTPs) contained individualized active treatment interventions to address specific psychiatric treatment needs of eight (8) of eight (8) active sample patients (A1, A2, A3, A4, A5, A6, A7, and A8). Specifically, MTPs failed to include active treatment interventions based on presenting psychiatric symptoms resulting in hospitalization. Instead, the interventions listed on the preprinted problem sheets were generic, routine discipline job duties, and did not consistently state a method of delivery, or a focus of treatment. These failures result in a lack of guidance for staff to provide coordinated and individualized active treatment, potentially delaying patient improvement and discharge from the hospital.	B 122			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 03/14/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 504012	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/20/2019
NAME OF PROVIDER OR SUPPLIER SMOKEY POINT BEHAVIORAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 3955 156TH STREET NORTHEAST MARYSVILLE, WA 98271		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
B 122	<p>Continued From page 25</p> <p>Findings include:</p> <p>A. Record Review</p> <p>The Master Treatment Plans (MTPs) for the following patients were reviewed (dates that plans were signed in parentheses): A1 (2/3/19), A2 (12/21/18), A3 (1/23/19), A4 (1/13/19), A5 (2/15/19), A6 (12/8/18), A7 (1/11/19), and A8 (2/28/19). This review revealed the following deficient interventions for psychiatric problems and treatment goals assigned to physicians (MD), registered nurses (RN), social work staff (SW), and activity therapist (AT).</p> <p>1. Patient A1's MTP included the following deficient intervention statements for the problem of "Reality Perception Impairment as Evidenced by: Disorganized and illogical thinking."</p> <p>a. MD Interventions: "MD will provide for physical exam to determine if organic factors may contribute to psychosis." "MD will evaluate severity of pt.'s [patient's] reality perception disturbance, prescribe medication and monitor effectiveness." These intervention statements included routine MD functions, were non-specific, and not individualized. The intervention regarding medication failed to include the name of the medication prescribed for the patient or plans to provide information regarding his/her psychiatric symptoms and medication such as benefits, side effects, and compliance issues.</p> <p>b. RN Intervention: "R.N. will educate pt/significant other on medication regimen, purpose, side effects and safety factors of ..." The content to be handwritten was left blank. This intervention statement failed to include whether</p>	B 122			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 03/14/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 504012	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/20/2019
NAME OF PROVIDER OR SUPPLIER SMOKEY POINT BEHAVIORAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 3955 156TH STREET NORTHEAST MARYSVILLE, WA 98271		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
B 122	<p>Continued From page 26</p> <p>the intervention would be conducted in individual or group sessions, did not state the medication(s) to be taught, or the focus of patient education based on assessed needs.</p> <p>c. SW Intervention: The problem noted above was identified as the number one problem. However, there was no designated SW intervention for this problem.</p> <p>d. AT Intervention: The problem noted above was identified as the number one problem. However, there was no designated AT intervention for this problem.</p> <p>For the problem of "Mood Instability: As Evidenced by: Yelling, reporting anger, impulsivity, depression," the deficient interventions were:</p> <p>a. RN Intervention: "R.N. will administer medications and document and monitor side effects and medication efficacy." This intervention statement included routine nursing duties of administering medications, documenting in the clinical record, and monitoring patients. This preprinted problem sheet had no active treatment interventions reflecting the RN meeting the patient in 1:1 sessions to discuss specific medications prescribed or providing patient teaching to address assessed needs. The identically worded intervention was also included for Patient A2 (see below).</p> <p>b. SW Intervention: "Will educate Pt. on depression as well as coping skills s/he can use to manage symptoms." This intervention statement was very broad and non-specific in that the statement failed to include a clear focus of treatment related to this patient's unique</p>	B 122			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 03/14/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 504012	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/20/2019
NAME OF PROVIDER OR SUPPLIER SMOKEY POINT BEHAVIORAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 3955 156TH STREET NORTHEAST MARYSVILLE, WA 98271		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
B 122	<p>Continued From page 27 depressive symptoms.</p> <p>c. AT Intervention: "Will encourage Pt. to engage in groups and educate on ways to cope through leisure skills." This intervention included a routine job duty of encouraging patients. The intervention failed to identify the particular groups to be delivered and a focus of treatment based on the patient's unique presenting symptoms. The frequency of the groups was listed as daily, albeit activity therapy groups were not available on the adult unit seven days per week.</p> <p>2. Patient A2's MTP included the following deficient intervention statements for the problem of "Reality Perception Impairment as Evidenced by: Schizoaffective Schizophrenia [sic]."</p> <p>a. MD Interventions: "Will meet with the patient and conduct an initial psychiatric assessment, prescribe medication as indicated, and review the risks and benefits of psychotropics medications." This intervention statement included routine MD functions assessing psychiatric symptoms, prescribing, and reviewing medications. The interventions were non-specific, not individualized and failed to include active treatment interventions reflecting meeting with the patient in individual sessions to provide information about prescribed medications and how to manage psychiatric symptoms. The intervention did not include the name of the medication to be prescribed.</p> <p>b. RN Intervention: "RN will administer medications and document and monitor side effects and medication efficacy." This intervention statement included routine nursing duties of administering medications, documenting in the clinical record, and monitoring patients. This</p>	B 122			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 03/14/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 504012	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/20/2019
NAME OF PROVIDER OR SUPPLIER SMOKEY POINT BEHAVIORAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 3955 156TH STREET NORTHEAST MARYSVILLE, WA 98271		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
B 122	<p>Continued From page 28</p> <p>preprinted problem sheet contained no active treatment interventions reflected the RN meeting with the patient in 1:1 sessions to discuss specific medications prescribed or providing patient teaching to address assessed psychiatric needs.</p> <p>c. SW Intervention: "Program Therapist will provide psychoeducation on diagnosis and introduce 3 copings skills to manage and reduce problem symptomology." This intervention statement was broad and non-specific in that the statement failed to include a clear focus of treatment related to the symptoms that brought the patient to the hospital.</p> <p>d. AT Intervention: "Recreational Therapist will encourage patient to participate in low level RT session and cue Pt as needed to focus on activity." This intervention included a routine job duty of encouraging patients. The intervention failed to identify the specific low-level RT groups to be delivered and a focus of treatment based on the patient's unique presenting symptoms. The frequency of the groups was listed as daily, albeit activity therapy groups were not available on the adult unit seven days per week.</p> <p>3. Patient A3's MTP included the following deficient intervention statements for the problem of "Danger to self with Psychosis as evidenced by: Self-care deficit due to inability to care for self & medical needs during psychotic episode."</p> <p>a. MD Interventions: "Order antipsychotic medications and titrate dosage in order to: [decrease] psychosis." "Individual sessions with patient to educate on symptom of psychosis." The intervention statement regarding ordering medications was a routine MD function and failed to identify the specific antipsychotic medication(s)</p>	B 122			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 03/14/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 504012	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/20/2019
NAME OF PROVIDER OR SUPPLIER SMOKEY POINT BEHAVIORAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 3955 156TH STREET NORTHEAST MARYSVILLE, WA 98271		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
B 122	<p>Continued From page 29</p> <p>ordered. The intervention regarding providing education was an active treatment intervention but failed to identify the purpose of education or the specific targeted psychotic symptoms to be addressed. This same intervention statement was also designated for Patient A4 (see below).</p> <p>b. RN Interventions: "Place patient on Suicide Precaution to prevent self-harm/suicidal behavior per physician order." "Help patient to identify triggers, warning signs and coping strategies for self-harmful behaviors on Care Profile and Crisis Plans." "When patient is displaying the following warning signs: loss of control, ask direct questions to determine if suicidal intent, plan for suicide, and means develops." [Note: Clinical data did not support these three intervention statements. The psychiatric evaluation, dated 1/22/19, reported that the patient "denies any suicidal or homicidal thoughts ..."]. "Assess for presence of hallucinations, delusions, internal stimuli at least once per shift ..." These intervention statements included routine nursing job duties or instructions to manage behavior not to provide treatment. This preprinted problem sheet had no active treatment interventions that reflected the RN meeting the patient in 1:1 sessions to discuss specific problems identified upon admission. These intervention statements were identical or similarly worded for Patients A4 and A6 (see below).</p> <p>c. SW Intervention: "Provide patient identified coping tools to reduce thoughts of self-harm: (Self-care deficit) breaths [sic], mindfulness, grounding & awareness." This intervention statement was very broad and non-specific in that the statement failed to describe the self-harm behavior and include a clear focus of treatment related to the psychiatric symptoms that brought</p>	B 122			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 03/14/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 504012	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/20/2019
NAME OF PROVIDER OR SUPPLIER SMOKEY POINT BEHAVIORAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 3955 156TH STREET NORTHEAST MARYSVILLE, WA 98271		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
B 122	<p>Continued From page 30 the patient to the hospital.</p> <p>d. AT Intervention: "Recreational Therapist will provide opportunities and educate Pt to activities to use as alternative coping skills to self-harm behavior." This intervention statement failed to describe the self-harm behavior, did not suggest appropriate RT groups or identify a focus of treatment based on the patient's unique presenting symptoms. The frequency of the groups was listed as daily, albeit activity therapy groups were not available on the adult unit seven days per week.</p> <p>4. Patient A4's MTP included the following deficient intervention statements for the problem of "Danger to Others as evidenced by: Aggressive bx [behavior] toward step-father."</p> <p>a. MD Interventions: "Order antipsychotic medications and titrate dosage in order to: [handwritten space left blank]. "Individual sessions with patient to educate on symptom of psychosis." The intervention statement regarding ordering medications was a routine MD function and failed to identify the specific antipsychotic medication(s) ordered. The intervention regarding providing education was an active treatment intervention but did not identify the purpose of education or the specific targeted psychotic symptoms to be addressed.</p> <p>b. RN Interventions: "Place patient on Assault, Homicidal precaution to prevent harm to peers/staff from aggressive behavior per physician order." "Help patient to identify triggers, warning signs and coping strategies for self-harmful behaviors on Care Profile and Crisis Plans." "When patient is displaying the following warning signs: ['fist clenching' inserted], ask direct</p>	B 122			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 03/14/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 504012	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/20/2019
NAME OF PROVIDER OR SUPPLIER SMOKEY POINT BEHAVIORAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 3955 156TH STREET NORTHEAST MARYSVILLE, WA 98271		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
B 122	<p>Continued From page 31</p> <p>questions to determine if aggressive thoughts develop." "Redirect patient from hostile or threatening behavior and prompt patient to utilize the following coping(s) skill: Deep breathing, concentrate on controlling anger." These intervention statements included routine nursing job duties or instructions to manage aberrant behavior not to provide treatment. This preprinted problem sheet required a frequency and duration to be identified. The sheet noted a frequency of "Per Episode" but had no duration of contact. Therefore, the MTP had no active treatment interventions showing the RN meeting with the patient in 1:1 sessions with a particular duration of time to discuss specific problems identified upon admission. "Medication education to increase understanding of the benefits and side effects of prescribed medications." Although this was an active treatment intervention statement, it failed to name the specific medication(s) to be taught.</p> <p>c. SW Intervention: "Therapist will assist patient in identifying warning signs and decompensation that result in aggressive behaviors through discussion on: [A list of seven topics including symptom recognition and problem solving.]" This intervention statement was non-specific in that the statement failed to describe the patient's aggressive behaviors and did not include a clear focus of treatment related to the symptoms that brought the patient to the hospital.</p> <p>d. AT Intervention: "Recreational Therapist will provide opportunities and educate Pt to activities to use coping skills as alternative to aggressive behavior toward others." This intervention statement failed to describe the aggressive behavior(s), did not suggest appropriate RT groups or include a focus of treatment based on</p>	B 122			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 03/14/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 504012	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/20/2019
NAME OF PROVIDER OR SUPPLIER SMOKEY POINT BEHAVIORAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 3955 156TH STREET NORTHEAST MARYSVILLE, WA 98271		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
B 122	<p>Continued From page 32 the patient's unique presenting symptoms.</p> <p>5. Patient A5's MTP included the following deficient intervention statements for the problem of "Danger to self with Psychosis as evidenced by: Pt. [Patient] having a plan for suicide and responding to internal stimuli."</p> <p>a. MD Interventions: "Order psychiatric medications and titrate dosage in to: reduce symptoms." "Individual sessions with patient to educate on symptom management of AH [auditory hallucination], anxiety, depression." The intervention statement regarding ordering medications was a routine MD function and failed to identify the specific antipsychotic medication(s) ordered. The intervention regarding providing education was an active treatment intervention but was non-specific in that it did not identify the patient unique presenting symptoms. The statement also failed to define the purpose or focus of education to be provided.</p> <p>b. RN Interventions: "Place patient on Suicide Precaution to prevent self-harm/suicidal behavior per physician order." "Help patient to identify triggers, warning signs and coping strategies for self-harmful behaviors on Care Profile and Crisis Plans." "When patient is displaying the following warning signs: Isolation, ask direct questions to determine if suicidal intent, plan for suicide, and means develops." "Assess for presence of hallucinations, delusions, internal stimuli at least once per shift ..." These intervention statements included routine nursing job duties or instructions to manage behavior not to provide treatment. This preprinted problem sheet did not include active treatment interventions reflecting the RN meeting with the patient in 1:1 sessions to discuss specific psychiatric problems identified</p>	B 122			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 03/14/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 504012	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/20/2019
NAME OF PROVIDER OR SUPPLIER SMOKEY POINT BEHAVIORAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 3955 156TH STREET NORTHEAST MARYSVILLE, WA 98271		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
B 122	<p>Continued From page 33 upon admission.</p> <p>c. SW Intervention: "Provide patient identified coping tools to reduce thoughts of self-harm: grounding activities, deep breathing." This intervention statement was very broad and non-specific in that the statement failed to describe the self-harm behavior and include a clear focus of treatment related to the symptoms that brought the patient to the hospital.</p> <p>d. AT Intervention: "RT will provide opportunities and educate Pt to activities to use as alternative coping skills to self-harm behavior." This intervention statement failed to describe the self-harm behavior, did not identify appropriate RT groups or a focus of treatment based on the patient's unique presenting symptoms. The frequency of the groups was listed daily, albeit activity therapy groups were not available on the Transitional Care Unit (TCU) seven days per week.</p> <p>6. Patient A6's MTP included the following deficient intervention statements for the problem of "Reality Perception Impairment as Evidenced by: Psychosis."</p> <p>a. MD Interventions: "MD will provide for physical exam to determine if organic factors may contribute to psychosis." "MD will evaluate severity of pt.'s [patient's] reality perception disturbance, prescribe medication and monitor effectiveness." These intervention statements included routine MD functions, were non-specific, and not individualized. The intervention regarding medication failed to include the name of the medication prescribed for the patient or plans to provide information regarding his/her psychiatric symptoms and medication such as benefits, side</p>	B 122			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 03/14/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 504012	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/20/2019
NAME OF PROVIDER OR SUPPLIER SMOKEY POINT BEHAVIORAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 3955 156TH STREET NORTHEAST MARYSVILLE, WA 98271		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
B 122	<p>Continued From page 34 effects, and compliance issues.</p> <p>b. RN Intervention: "R.N. will educate pt/significant other on medication regimen, purpose, side effects and safety factors ... and will assess pt's response to medication." [The content to be handwritten was left blank.] This intervention statement failed to include whether the intervention would be conducted in individual or group sessions, did not state the medication(s) to be taught, or the focus of patient education based on assessed needs. There were three other RN interventions identified for this problem that were all routine RN duties of monitoring behavior, maintaining a safe environment, and providing support.</p> <p>c. SW Intervention: "Program Therapist will educate pt. on realistic discharge plan based on needs." This intervention statement was non-specific in that the statement failed to include anticipated aftercare plan or a clear focus of treatment related to the discharge needs identified in social work assessments.</p> <p>d. AT Intervention: "Rec Therapist will provide recreational activities that are non-threatening and simple to master, and encourage a low level of social interaction." The intervention failed to identify the particular RT activities that were non-threatening. The frequency of the groups was listed daily, albeit activity therapy groups were not available on the TCU seven days per week.</p> <p>7. Patient A7's MTP included the following deficient intervention statements for the problem of "Depressed Mood."</p> <p>a. MD Intervention: "Physician will order</p>	B 122			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 03/14/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 504012	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/20/2019
NAME OF PROVIDER OR SUPPLIER SMOKEY POINT BEHAVIORAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 3955 156TH STREET NORTHEAST MARYSVILLE, WA 98271		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
B 122	<p>Continued From page 35</p> <p>anti-depression [sic] medication of Klonopin and evaluate the effectiveness." Ordering medications was a routine MD function. Although the intervention identified the specific medications, there was no intervention reflecting meeting with the patient to provide information regarding medication and targeted psychiatric symptom management.</p> <p>b. RN Interventions: "Staff will perform 15 checks [sic] on patient." "Staff will encourage pt to verbalize feelings when wanting to harm self." "Staff will obtain safety plan." "RN will administer the medication, as ordered." All of these intervention statements were routine nursing duties or instructions to maintain safety. This preprinted problem sheet included no active treatment interventions reflecting the RN meeting with the patient in 1:1 sessions to discuss specific medications prescribed or providing patient teaching related to presenting psychiatric symptoms.</p> <p>c. SW Interventions: "Assist patient to identify three triggers of feeling helplessness and to develop alternative coping skills to deal with the feelings." "Maintain a therapeutic environment to assist the patient to cope with feelings of depression." These intervention statements were non-specific and failed to be directly related to this patient's identified psychiatric symptoms. These intervention statements were identical or similarly worded for Patient A8. There was no clinical data to support the problem of depressed mood. The patient's diagnosis was "Alcohol Use Disorder, severe" and there was no other diagnosis.</p> <p>d. AT Intervention: "Engage the patient to develop new coping skills, and achieve a positive outcome</p>	B 122			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 03/14/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 504012	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/20/2019
NAME OF PROVIDER OR SUPPLIER SMOKEY POINT BEHAVIORAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 3955 156TH STREET NORTHEAST MARYSVILLE, WA 98271		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
B 122	<p>Continued From page 36</p> <p>and increase feelings of self-fulfillment." The intervention failed to identify the particular groups to be delivered and a focus of treatment based on the patient's unique presenting symptoms.</p> <p>8. Patient A8's MTP included the following deficient intervention statements for the problem of "Depressed Mood."</p> <p>a. MD Intervention: "Physician will order anti-depression medication of Olanzapine and evaluate the effectiveness." Ordering medications was a routine MD function. Although the intervention identified the specific medications, there was no intervention reflecting meeting with the patient to provide information regarding medication and targeted psychiatric symptom management.</p> <p>b. RN Interventions: "Staff will perform Q15 checks on patient." "Staff will encourage pt to verbalize feelings when wanting to harm self." "Staff will obtain safety plan." "RN will administer the medication, as ordered." All of these intervention statements were routine nursing duties or instructions to maintain safety. This preprinted problem sheet contained no active treatment interventions reflecting the RN meeting with the patient in 1:1 sessions to discuss specific medications prescribed or providing patient teaching related to presenting psychiatric symptoms.</p> <p>c. SW Interventions: "Assist patient to identify three triggers of feeling helplessness and to develop alternative coping skills to deal with the feelings." "Maintain a therapeutic environment to assist the patient to cope with feelings of depression." These intervention statements were non-specific and had no information that</p>	B 122			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 03/14/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 504012	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/20/2019
NAME OF PROVIDER OR SUPPLIER SMOKEY POINT BEHAVIORAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 3955 156TH STREET NORTHEAST MARYSVILLE, WA 98271		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
B 122	Continued From page 37 described the patient's helplessness. The intervention regarding a therapeutic environment was a routine clinical function. Also, the intervention statements failed to be directly related to this patient's identified psychiatric symptoms. There was no clinical data to support the problem of depressed mood. The patient's diagnosis was "Bipolar disorder type1, most recent episode manic with psychotic features." d. AT Intervention: "Engage the patient to develop new coping skills, and achieve a positive outcome and increase feelings of self-fulfillment." The intervention failed to identify the particular groups to be delivered and a focus of treatment based on the patient's unique presenting symptoms. B. Interviews 1. In an interview on 2/19/19 at 11:37 a.m., with RN2, the active sample patients' Master Treatment Plans were discussed. RN2 acknowledged that the interventions were routine nursing functions and that in some instances goal statements were written as interventions. 2. During an interview on 2/20/19 at 9:50 a.m. with the Director of Nursing, the MTPs of the active patient sample were discussed. She did not dispute the findings that nursing interventions contained routine RN job duties and did not consistently include active treatment intervention statements with a focus of treatment based on the patient's reason for hospitalization.	B 122			
B 124	TREATMENT PLAN CFR(s): 482.61(c)(1)(v) The written plan must include adequate documentation to justify the diagnosis and the	B 124			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 03/14/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 504012	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/20/2019
NAME OF PROVIDER OR SUPPLIER SMOKEY POINT BEHAVIORAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 3955 156TH STREET NORTHEAST MARYSVILLE, WA 98271		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
B 124	<p>Continued From page 38 treatment and rehabilitation activities carried out.</p> <p>This Standard is not met as evidenced by: Based on record review and interview, the facility failed to ensure that detailed treatment notes were documented by registered nurses (RN) and social workers (SW) regarding active treatment interventions from the Master Treatment Plan and for alternative interventions when required for four (4) of four (4) active sample patients (A5, A6, A7, and A8) reviewed for treatment notes. Specifically, documentation did not consistently show if the interventions were carried out, and if recorded, the note failed to include details regarding the patients' response to the interventions, including the understanding of the information provided, the level of participation, and specific patient comments if any. Also, there was limited information about the alternatives offered when patients refused to participate in group treatment. This failure hinders the treatment team in determining the patients' response to active treatment interventions, evaluating if there were measurable changes in the patients' condition and revising the treatment plan when the patient did not respond to treatment interventions.</p> <p>Findings include:</p> <p>1. Patient A5: The medical record had the following deficient treatment notes for interventions on the MTP last signed 2/15/19:</p> <p>a. Nursing Intervention: "Medication education to increase understanding of the benefits and side effects of prescribed medications." The frequency was "1 x [times] a week for 30 minutes." A review</p>	B 124			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 03/14/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 504012	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/20/2019
NAME OF PROVIDER OR SUPPLIER SMOKEY POINT BEHAVIORAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 3955 156TH STREET NORTHEAST MARYSVILLE, WA 98271		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
B 124	<p>Continued From page 39</p> <p>of the medical record from 2/10/19 through 2/18/19 revealed that there were no treatment notes documented on the "Group Note" or the "Daily Nursing Progress Note" Forms to show that this intervention was implemented in individual or group sessions.</p> <p>The "Group/Activity Schedule" for the TCU showed an RN group titled "Medication Education" group scheduled Saturdays from 1:30 p.m. to 2:30 p.m. This was a group available to address this intervention, but there was no documented to reflect the patient's attendance or non-attendance in this group.</p> <p>b. Social Work Interventions: "Will educate Pt on Depression as well as copings s/he use to manage symptoms." "Therapist will promote the utilization of coping skills to deal with feelings of anxiety including guided imagery ... utilizing DBT therapy." These sessions were to be implemented weekly. One intervention to be implemented during and individual sessions was "Provide patient identified coping tools to reduce thoughts of self-harm: grounding activities, deep breathing." The frequency was weekly. A review of group notes and medical record from 2/10/19 through 2/18/19 revealed that there were no treatment notes written by social workers to show that these interventions were implemented in either group or individual sessions.</p> <p>The "Group/Activity Schedule" for the TCU showed a therapist group titled "CBT [Cognitive Behavioral Therapy] Process Group" scheduled Monday through Friday from 1:30 p.m. to 2:30 p.m. and a group titled "Process Group: Healthy Relationship ..." scheduled Saturdays from 10:15 a.m. to 11:00 a.m. These were groups available to address these interventions, but there was no</p>	B 124			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 03/14/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 504012	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/20/2019
NAME OF PROVIDER OR SUPPLIER SMOKEY POINT BEHAVIORAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 3955 156TH STREET NORTHEAST MARYSVILLE, WA 98271		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
B 124	<p>Continued From page 40</p> <p>documented evidence to reflect the patient's attendance or non-attendance in these groups. There was no DBT Group on the unit schedule.</p> <p>2. Patient A6: The medical record had the following deficient treatment notes for interventions on the MTP signed 12/8/18:</p> <p>a. Nursing Intervention: "R.N. will educate pt/significant other on medication regimen, purpose, side effects and safety factors of ... and will assess pt's response to medication" The content to be handwritten was left blank. The frequency was weekly. A review of the medical record from 2/10/19 through 2/18/19 revealed that there were no treatment notes documented on the "Group Note" or the "Daily Nursing Progress Note" Forms regarding individual or group sessions provided by RNs.</p> <p>b. Social Work Interventions: "Program Therapist will educate pt. on realistic discharge plan based on needs." The frequency was weekly. "Therapist will promote the utilization of new coping skills to deal with feelings of anxiety, including guided imagery and other relaxation techniques utilizing DBT therapy." The frequency was weekly. A review of group notes and the medical record from 2/10/19 through 2/18/19 revealed that there was two "Group Note" dated 2/12/19 and 2/13/19. There was no information in group notes or individual sessions regarding educating the patient regarding discharge planning and DBT therapy. The group note dated 2/12/19 showed that the patient refused and the item titled "Group material offered to complete independently" was circled. There was no information regarding what group material was offered to the patient. The group noted dated 2/13/19 showed the preprinted form contained limited information about the</p>	B 124			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 03/14/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 504012	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/20/2019
NAME OF PROVIDER OR SUPPLIER SMOKEY POINT BEHAVIORAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 3955 156TH STREET NORTHEAST MARYSVILLE, WA 98271		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
B 124	<p>Continued From page 41</p> <p>patient's response to the group session. There was no information about the patient level of understanding or any comments the patient made during the session.</p> <p>The "Group/Activity Schedule" for the TCU showed a therapist group titled "CBT [Cognitive Behavioral Therapy] Process Group" scheduled Monday through Friday from 1:30 p.m. to 2:30 p.m. and a group titled "Process Group: Healthy Relationship ..." scheduled Saturdays from 10:15 a.m. to 11:00 a.m. These groups were available to address these interventions. Except for the two group notes with topics regarding stress management and grounding techniques, there was no other documented evidence related to the patient's attendance or non-attendance in these groups to address the identified interventions. There was no DBT group listed on the schedule.</p> <p>3. Patient A7: The medical record had the following deficient treatment notes for interventions on the MTP signed 1/11/19:</p> <p>a. Nursing Intervention: "Medication education to increase understanding of the benefits and side effects of prescribed medications." The frequency was one (1) a week for 30 minutes. A review of the medical record from 2/10/19 through 2/18/19 revealed that there were no treatment notes documented on the "Group Note" or the "Daily Nursing Progress Note" Forms regarding individual or group sessions provided by RNs.</p> <p>b. Social Work Interventions: "Assist patient to identify three triggers of feeling helplessness and to develop alternative coping skills to deal with the feelings." The frequency was "3 times a week for 45 minutes in process group utilizing CBT." "Therapist will promote the utilization of coping</p>	B 124			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 03/14/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 504012	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/20/2019
NAME OF PROVIDER OR SUPPLIER SMOKEY POINT BEHAVIORAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 3955 156TH STREET NORTHEAST MARYSVILLE, WA 98271		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
B 124	<p>Continued From page 42</p> <p>skills to deal with feelings of anxiety including guided imagery ... utilizing DBT therapy. The frequency was "At least weekly." A review of group notes from 2/10/19 through 2/18/19 revealed that there was one "Group Note" recorded dated 2/18/19. There were no other treatment notes by social workers to show that group or individual sessions for these interventions were implemented during this period.</p> <p>The "Group/Activity Schedule" for the Military Unit showed therapist groups scheduled as follows: A variety of group topics (CBT, Anger Management, Relapse Prevention) scheduled Monday through Friday from 9:45 a.m. to 10:35 p.m.; "Process Groups scheduled from 11:00 a.m. to 11:50 p.m. Monday through Thursday; and "Cognitive Behavioral ... scheduled from 2:00 p.m. to 3:00 p.m. Monday through Friday. These groups were available to address these interventions. Except for the one group with a top of "Assertive Communication ..." there was no other documented evidence to reflect the patient's attendance or non-attendance in these groups the review period.</p> <p>4. Patient A8: The medical record had the following deficient treatment notes for interventions on the MTP signed 12/8/18:</p> <p>a. Nurse Interventions: "Discuss activities that may aide [sic] in easing the stress until the anxiety can be relieved." The frequency was "as needed." "Assist the pt. [patient] to utilize successful coping methods to manage anxiety, such as progressive relaxation technique, deep breathing exercises, and visual imagery." The MTP noted "as needed" as the frequency, "Medication education to increase understanding</p>	B 124			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 03/14/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 504012	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/20/2019
NAME OF PROVIDER OR SUPPLIER SMOKEY POINT BEHAVIORAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 3955 156TH STREET NORTHEAST MARYSVILLE, WA 98271		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
B 124	<p>Continued From page 43</p> <p>if of the benefits and side effects of prescribed medications." The frequency was weekly for 30 minutes. A review of the medical record from 2/10/19 through 2/18/19 revealed that there were no treatment notes documented on the "Group Note" or the "Daily Nursing Progress Note" Forms regarding individual or group sessions provided by RNs.</p> <p>The "Group/Activity Schedule" for the Intensive Care Unit showed RN a "Medication/Mgmt. [Management] /Education group scheduled Sunday from 4:00 p.m. to 4:30 p.m. This was a group available to address the medication education intervention, but there was no documented evidence to reflect the patient's attendance or non-attendance in this group during the review period.</p> <p>b. SW Interventions: "Assist patient to identify three triggers of feeling helplessness and to develop alternative coping skills to deal with the feelings." The frequency was "3 times a week for 45 minutes." "Therapist will promote the utilization of new coping skills to deal with feelings of anxiety, including guided imagery and other relaxation techniques utilizing DBT [Dialectical Behavior Therapy] therapy [sic]." The frequency was "Weekly." "Therapist will assist patient in identifying warning signs and decompensation that result in aggressive behaviors through discussion on: [A list of seven topics including symptom recognition and problem-solving.]" This was a CBT [Cognitive Behavior Therapy] Process Group with a frequency of "30 minutes daily." "Discuss with and assist patient in understanding how physical indicators of stress, pacing, [increased] anxiety, crying, feeling depressed as identified on the Care Profile and Crisis Plan can affect functioning and symptom management."</p>	B 124			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 03/14/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 504012	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/20/2019
NAME OF PROVIDER OR SUPPLIER SMOKEY POINT BEHAVIORAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 3955 156TH STREET NORTHEAST MARYSVILLE, WA 98271		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
B 124	<p>Continued From page 44</p> <p>This intervention was a scheduled individual session with a frequency of "20 minutes weekly." A review of group notes from 2/10/19 through 2/18/19 revealed that there were three "Group Note" Forms with treatment notes dated 2/10/19, 2/14/19, and 2/15/19 for these interventions written by social workers. There were no other treatment notes by social workers to show that group or individual sessions for the identified interventions were implemented during this period.</p> <p>The "Group/Activity Schedule" for the Intensive Care Unit showed therapist groups titled "CBT Process Group" scheduled Sunday through Saturday from 1:00 p.m. to 1:30 p.m. This group was available to address these interventions. Except for three group notes with topics regarding "thoughts and feeling Actions," "Relaxation," and "Self Esteem: All about me," there was no other documented evidence during the review period related to the identified interventions. There was no DBT group listed on the schedule.</p> <p>B. Interview</p> <p>During an interview on 2/20/19 at 9:50 a.m. with the Director of Nursing, nursing interventions on the MTPs were discussed. Active sample Patient A5 record was reviewed to show lack of documentation. She did not dispute the findings that treatment notes were not being recorded to show that nursing interventions on the MTPs were implemented.</p>	B 124			
B 125	<p>TREATMENT PLAN</p> <p>CFR(s): 482.61(c)(2)</p> <p>The treatment received by the patient must be documented in such a way to assure that all active therapeutic efforts are included.</p>	B 125			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 03/14/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 504012	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/20/2019
NAME OF PROVIDER OR SUPPLIER SMOKEY POINT BEHAVIORAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 3955 156TH STREET NORTHEAST MARYSVILLE, WA 98271		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
B 125	<p>Continued From page 45</p> <p>This Standard is not met as evidenced by: Based on observation, record review, and interview, the facility failed to provide all necessary treatment measures to patients on three (3) of five Units (Open Adult, Intensive Care, and Transitional Care) of the facility. The facility failed to:</p> <p>I. Ensure that active treatment measures were provided for two (2) of five (5) active sample patients (A1 and A8) on these three units who did not attend or participate in treatment groups listed on the unit schedules. Specifically, there was an inadequate frequency and intensity of groups to assist with the patients' treatment. None of these groups were specifically related to patient goals on the treatment plans. Also, there was no consistent documentation in the medical record to show attempts to engage patients in alternative active treatment measures when they chose not to attend groups, which for some patients was a consistent finding. Despite inconsistent or lack of regular attendance in groups, the Master Treatment Plans (MTPs) were not revised to reflect alternative treatment measures to assist patients in achieving treatment goals. Failure to provide active treatment at a sufficient level and intensity results in affected patients being hospitalized without all active treatment interventions for recovery, thereby delaying their improvement.</p> <p>Findings include:</p> <p>A. Patient A1</p> <p>Deficiency: Insufficient active treatment</p>	B 125			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 03/14/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 504012	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/20/2019
NAME OF PROVIDER OR SUPPLIER SMOKEY POINT BEHAVIORAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 3955 156TH STREET NORTHEAST MARYSVILLE, WA 98271		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
B 125	<p>Continued From page 46 Record Review</p> <p>Review of "Group Note," "Daily Group Attendance Record," "Daily Nursing Progress Note" and "Interdisciplinary Group Note" forms for sample patient A1 for the period 2/11/19 - 2/18/19 revealed the following:</p> <p>1. The "Daily Group Attendance Record" listed the meetings led by Mental Health Technicians (MHTs) and included a Community Meeting, a Recreation/Social event, and a Wrap-Up group. Patient A1 attended the Community meeting on 2/11/19, 2/12/19, and 2/14/19-2/16/19. Patient A1 "attended and participated" at Recreation/Social 2/11/9 and 2/14/19. On the other days, the record stated the patient was offered an alternative activity for the Recreation/Social, but there was no evidence as to the nature of the alternative in the record. The patient attended one "Wrap up Group" on 2/13/19, refused all others.</p> <p>2. The "Group Note" sheets listed groups provided as therapy groups. The schedule noted two groups per day and a "Rec. Therapy" group twice a week (Music Therapy and Yoga once each per week.) The sheets for patient A1 documented the following;</p> <p>a. On 2/11/19 (time not noted), for "Emotional Management/Exploring Experiences," the box was checked which stated, "Silent But Attentive" and the Summary stated, "Pt did not wish to share in the discussion." The "Short Term Goals" printed on the form were "Identify 3 positive traits." This goal was not documented on the MTP or the updates of Patient A1 (see section above for the dates of these documents).</p> <p>b. On 2/12/19, the only "Group Note" was for</p>	B 125			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 03/14/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 504012	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/20/2019
NAME OF PROVIDER OR SUPPLIER SMOKEY POINT BEHAVIORAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 3955 156TH STREET NORTHEAST MARYSVILLE, WA 98271		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
B 125	<p>Continued From page 47</p> <p>"Emotional Management/Exploring Experiences" (time not noted), where patient attended, and the Summary noted s/he "appeared to be responding to internal stimuli."</p> <p>c. On 2/13/19, the patient attended two groups at 10:30 a.m. and 11:00 a.m. where s/he was noted to say that s/he was having delusions (see section below).</p> <p>d. On 2/14/19, the patient attended an RT group at 11:15; minimally participated in a Group at 1:30 p.m. [laughing "inappropriately" and saying s/he "was very confused"].</p> <p>e. On 2/15/19, the "Group Note" sheets show s/he participated in two therapy groups (at 10:30 and 11:00 a.m.) and actively participated; the pt. engaged in Yoga provided by RT at 2:30 p.m.</p> <p>f. On 2/16/19, no Group Notes were in the record.</p> <p>g. On 2/17/19, the Group Note sheet for "Recovery" at 10:15 a.m. stated the patient actively participated. No other group notes were in the record.</p> <p>h. On 2/18/19, no Group notes were in the record.</p> <p>Of the two therapy groups available per day, the patient attended only those noted above. No other groups were available to the patient, and no individual therapy was provided.</p> <p>Deficiency: Inadequate and inconsistent treatment planning</p> <p>Record Review</p>	B 125			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 03/14/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 504012	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/20/2019
NAME OF PROVIDER OR SUPPLIER SMOKEY POINT BEHAVIORAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 3955 156TH STREET NORTHEAST MARYSVILLE, WA 98271		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
B 125	<p>Continued From page 48</p> <p>1. The MTP of Patient A1, signed 2/3/19, listed as Problem #1 "Reality Perception Impairment as evidenced by disorganized and illogical thinking," and Problem #3 as "Mood Instability as evidenced by yelling, reporting anger, impulsivity, depression." No modalities for either of these problems included any therapy groups, although, for the problem of Mood Instability, the Recreational Therapist's stated role was to "encourage Pt to engage in [unnamed] groups"</p> <p>2. Review of "Interdisciplinary Treatment Plan Review/Update [ITP]" forms of 2/6/19 and 2/13/19 revealed the following:</p> <p>The ITP form of 2/6/19, for Problem #1 stated, "Patient currently denies ah/vh [auditory and visual hallucinations.]" The ITP form for 2/13/19, for Problem #1 stated, "Pt's thought process is clear; problem resolved."</p> <p>3. Review of "Group Note," "Daily Group Attendance Record," "Daily Nursing Progress Note" and "Interdisciplinary Group Note" forms for the period 2/11/19-2/18/19 revealed the following:</p> <p>a. Process group on 2/12/19 (time not specified) stated, "Pt. appeared to be responding to internal stimuli; observed sitting by [him/herself] laughing without prompt."</p> <p>b. "Group Note" 2/13/19 at 10:30 a.m. stated, "Pt. shared about how [s/he] has been confused and having thoughts that [s/he] is in the television and that other people are control [sic] [his/her] thoughts. Pt said that [s/he] thinks that is some kind of conspiracy of the media."</p>	B 125			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 03/14/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 504012	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/20/2019
NAME OF PROVIDER OR SUPPLIER SMOKEY POINT BEHAVIORAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 3955 156TH STREET NORTHEAST MARYSVILLE, WA 98271		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
B 125	<p>Continued From page 49</p> <p>c "Group Note" 2/13/19 at 11:00 a.m. stated, "Pt. was able to listen to [his/her] peers and therapist about the idea that these thoughts could be delusions and associated with [his/her] mental illness. Pt. appeared to ...entertain the idea that these thoughts aren't reality."</p> <p>d."Group Note" 2/13/19 at 1:30 p.m. stated, "Pt. appeared to be unfocused and inattentive. Pt. would laugh inappropriately and say that [s/he] was very confused and 'what's going on?'"</p> <p>e. "Group Note" 2/15/19 at 11:00 a.m. stated, "Pt said that [s/he] is having thoughts that 'waves of energy' are coming at [him/her], especially from the television." However, a "Group Note" at 10:30 a.m. on 2/15/19 states "Pt. made partial progress by participating in group therapy appropriatelyPt said ...that [s/he] thinks the meds are improving [his/her] symptoms ..."</p> <p>4. On the "Daily Nursing Progress Note" for 2/15/19 [day shift] the RN circled "None" in the areas of "Delusions" and "Hallucinations."</p> <p>These notes were contradictory and inconsistent with the documentation on the Treatment plan updates, and there was no documentation in the Treatment plan or updates to reconcile the discrepancies about patient progress related to Problem #1. In addition, the treatment plan updates did not address the fact that the patient was refusing a number of groups, and since there was no individual therapy, what modalities could be initiated to engage the patient in therapy. (See Section above for group attendance detail.)</p> <p>Interview</p> <p>In an interview 2/19/19 at 2:30 p.m. with the</p>	B 125			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 03/14/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 504012	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/20/2019
NAME OF PROVIDER OR SUPPLIER SMOKEY POINT BEHAVIORAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 3955 156TH STREET NORTHEAST MARYSVILLE, WA 98271		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
B 125	<p>Continued From page 50</p> <p>therapist who provided all groups except the 10:30 a.m. group on 2/15/19, she stated that she only knows about the patients from what they say in her group meetings. She does not attend treatment team meetings, does not review charts, and her communication with the treatment team is through the notes she puts in the chart at each group meeting she leads.</p> <p>B. Patient A8:</p> <p>1. Patient A8 was admitted on 12/26/18. The patient's psychiatric evaluation, dated 12/28/18, had a provisional psychiatric diagnosis of "Bipolar disorder type1, most recent episode manic with psychotic features." The psychiatric evaluation reported " ... The patient had unexpectedly jumped out of the car and left the house without shoes ... has increased mood lability ... very poor hygiene ... not sleeping for days and not taking any medications"</p> <p>2. During an observation on the Intensive Care Unit (ICU) on 2/18/19 at 1:15 p.m., Patient A8 was walking in the hallway during the time a group titled, "CBT Process Group" scheduled from 1:00 p.m. to 1:30 p.m. was being held in the group room. During a discussion at approximately 1:15 p.m., when asked why Patient A8 was not attending the group, MHT3 stated, "[S/he] usually doesn't attend groups, or goes in but doesn't stay, and mostly stays in [his/her] room."</p> <p>3. In an interview on 12/18/19 after the group, SW1 stated that she goes to patients who do not attend groups and discusses the handout from the group. When asked if staff revise the treatment plan for patients who consistently refuse to participate in the group treatment program, she stated, "We don't have a problem</p>	B 125			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 03/14/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 504012	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/20/2019
NAME OF PROVIDER OR SUPPLIER SMOKEY POINT BEHAVIORAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 3955 156TH STREET NORTHEAST MARYSVILLE, WA 98271		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
B 125	<p>Continued From page 51</p> <p>sheet for patients that don't come to the group." The lack of involvement in active treatment by active sample patient A8 was also discussed. SW1 did not dispute the finding and acknowledged that this patient was not participating consistently in active treatment on the unit.</p> <p>4. Patient A8's MTP, signed 12/28/18, outlined three psychiatric problems: "Mood Instability/ Depressed mood, Anxiety, and Danger to others with psychosis." The following findings represent the extent to which active treatment interventions identified in the MTP for these problems were implemented and documented by clinical staff.</p> <p>a. Registered Nurses (RN)</p> <p>1) RN Interventions: "Discuss activities that may aide [sic] in easing the stress until the anxiety can be relieved." The frequency was "as needed." "Assist the pt. [patient] to utilize successful coping methods to manage anxiety, such as progressive relaxation technique, deep breathing exercises, and visual imagery." The MTP noted "as needed" as the frequency of contact. [Therefore, this intervention had no planned frequency of contact with the patient.] "Medication education to increase understanding of the benefits and side effects of prescribed medications." The frequency was weekly for 30 minutes. "Talk with Patient about why medication compliance is helpful to control symptoms." The frequency was Q Med Pass [every medication pass].</p> <p>2) RN documentation of active treatment: The review of group treatment and progress notes written by registered nurses from 2/6/19 through 2/18/19 revealed that there were no group treatment notes for the medication education group. A review of the "Daily Group Attendance"</p>	B 125			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 03/14/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 504012	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/20/2019
NAME OF PROVIDER OR SUPPLIER SMOKEY POINT BEHAVIORAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 3955 156TH STREET NORTHEAST MARYSVILLE, WA 98271		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
B 125	<p>Continued From page 52</p> <p>and "Daily Nursing Progress Note" Forms from 2/6/19 through 2/18/19 revealed no documentation of group or individual sessions with the patient to implement the interventions assigned on the MTP.</p> <p>b. Social Workers (SW)</p> <p>1) SW Interventions: "Assist patient to identify three triggers of feeling helplessness and to develop alternative coping skills to deal with the feelings." The frequency was "3 times a week for 45 minutes." "Therapist will promote the utilization of new coping skills to deal with feelings of anxiety, including guided imagery and other relaxation techniques utilizing DBT [Dialectical Behavior Therapy] therapy [sic]." The frequency was "Weekly." "Therapist will assist patient in identifying warning signs and decompensation that result in aggressive behaviors through discussion on: [A list of seven topics including symptom recognition and problem-solving.]" This was a CBT [Cognitive Behavior Therapy] Process Group with a frequency of "30 minutes daily." "Discuss with and assist patient in understanding how physical indicators of stress, pacing, [increased] anxiety, crying, feeling depressed as identified on the Care Profile and Crisis Plan can affect functioning and symptom management." This intervention was a scheduled individual session with a frequency of "20 minutes weekly."</p> <p>2) SW documentation of active Treatment: The review of group treatment and progress notes by social workers from 2/6/19 through 2/18/19 revealed that out of the possible 11 group sessions, there were three (3) group notes found for 2/10/19, 2/14/19, and 2/15/19. The patient attended the group sessions on 2/10/19 and 2/15/19. On 2/15/19, it was documented that the patient was "confused and in and out of the</p>	B 125			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 03/14/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 504012	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/20/2019
NAME OF PROVIDER OR SUPPLIER SMOKEY POINT BEHAVIORAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 3955 156TH STREET NORTHEAST MARYSVILLE, WA 98271		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
B 125	<p>Continued From page 53</p> <p>group." The patient refused the group on 2/14/19 and the group treatment notes circled "Group material offered to complete independently."</p> <p>There was no documentation showing the topics of the material, that the social worker met with the patient or the patient's response to the materials provided.</p> <p>c. Activity Therapists (AT)</p> <p>1) AT Intervention: "Engage the patient to develop new coping skills, and achieve a positive outcome and increase feelings of self-fulfillment." This AT group was scheduled for "45 minutes a day three days/week." "Recreation Therapist will provide opportunities and educate Pt to activities to use as coping skills as alternatives to aggressive behavior towards others." The frequency was "45 minutes daily."</p> <p>2) AT documentation of active treatment: The review of group treatment and progress notes by activity therapist from 2/6/19 through 2/18/19 revealed that out of the possible 10 group sessions, there were six (6) group treatment notes located. This review showed that the patient refused three groups 2/11/19, 2/14/19, and 2/18/19 and participated in three groups 2/12/19, 2/15/19, and 2/17/19. For the groups refused, the treatment notes checked "Group material offered to complete independently." However, there was no documentation to show that the activity therapist met or attempted to meet with the patient to discuss the group material provided and the patient's response to these interventions.</p> <p>5. The untitled forms used to document the location of patients every 15 minutes were reviewed for the period from 2/10/19 through 2/18/19. This review revealed the patient was</p>	B 125			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 03/14/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 504012	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/20/2019
NAME OF PROVIDER OR SUPPLIER SMOKEY POINT BEHAVIORAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 3955 156TH STREET NORTHEAST MARYSVILLE, WA 98271		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
B 125	<p>Continued From page 54</p> <p>recorded as being in his/her bedroom during times groups were held. The patient was on occasions documented to be in the hallway or dayroom. The following sample data outlined the patient's location during group sessions.</p> <p>a. Sunday: On 2/10/19, from 10:00 a.m. to 10:45 a.m., during the recreational therapy group, the patient was located in his/her bedroom and the hallway; from 11:15 a.m. to 12:00 p.m., the patient was located in his/her bedroom during the recovery group; from 1:00 p.m. to 1:30 p.m., the patient was located in the hallway during the CBT process group; and from 4:00 p.m. to 4:30 p.m., the patient was located in his/her bedroom, in the hallway, and at the nursing station during the scheduled Medication Education Group.</p> <p>b. Tuesday: On 2/13/19, from 10:00 a.m. to 10:45 a.m., during music therapy the patient was located in his/her bedroom; from 11:15 a.m. to 12:00 p.m., patient was located in his/her bedroom during the recovery group; and from 1:00 p.m. to 1:30 p.m., the patient was located in his/her bedroom during the CBT process group.</p> <p>c. Thursday: On 2/14/19, from 10:00 a.m. to 10:45 a.m., during the recreational therapy group, the patient was located in his/her bedroom and at the nursing; from 11:15 a.m. to 12:00 p.m., patient was located in his/her bedroom during the recovery group; and from 1:00 p.m. to 1:30 p.m., the patient was located in his/her bedroom during the CBT process group.</p> <p>d. Saturday: On 2/17/19, from 11:15 a.m. to 12:00 p.m., the patient was located in his/her bedroom and bathroom during the recovery group; from 1:00 p.m. to 1:30 p.m., the patient was located in his/her bedroom during the CBT</p>	B 125			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 03/14/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 504012	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/20/2019
NAME OF PROVIDER OR SUPPLIER SMOKEY POINT BEHAVIORAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 3955 156TH STREET NORTHEAST MARYSVILLE, WA 98271		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
B 125	<p>Continued From page 55</p> <p>process group; and from 4:00 p.m. to 4:30 p.m., the patient was located in his/her bedroom, during the scheduled nursing group, titled "Healthy Lifestyles" Group.</p> <p>6. During an observation on the ICU on 2/19/19 from 11:15 a.m. - 11:40 a.m., a group titled "Recovery Group" was held. Only three of the 12 patients on the census were in the scheduled group. The surveyor discussed the location of the patients that were not attending the scheduled group with MHT3 at 11:25 am. MHT3 stated, "The rest of the patients are in their rooms sleeping or walking the hallway." Patient A8 was in the hallway but went to the group after the corporate staff asked her to go to the group for five minutes. Patient A8 walked in the group room and sat down for two minutes and left.</p> <p>7. Despite the documentation of the patient's lack of involvement in active treatment, the MTP was not revised for Patient A8 to include alternative individual active treatment measures designed to engage the patient to ensure planned contacts regularly. There was limited evidence to show attempts to engage this patient in active treatment.</p> <p>II. Ensure sufficient therapy modalities, and in a confidential setting, for patients on two of five Units (Open Adult and Transitional Care) to meet patient needs. This failure results in patients not participating in the active treatment modalities, and can hinder progress towards discharge.</p> <p>Findings include:</p> <p>A. Program review</p>	B 125			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 03/14/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 504012	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/20/2019
NAME OF PROVIDER OR SUPPLIER SMOKEY POINT BEHAVIORAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 3955 156TH STREET NORTHEAST MARYSVILLE, WA 98271		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
B 125	<p>Continued From page 56</p> <p>Review of the program schedules for Open Adult and Transitional Care Units showed three groups per day listed: A "Recovery Group" (seven days a week on the Open Adult Unit and five days a week on the Transitional Care Unit), a "Rec Therapy" group (six days a week on the Transitional Unit, and twice a week on the Open Adult unit), and a "Process Group" (six days a week on the Open Adult Unit and seven days a week on the Transitional Care Unit). Although there was a Women's Group every weekday both morning and afternoon, it was not on the schedules.</p> <p>Staff stated that patients were not assigned to any specific groups, but could attend group if they chose. For patients who did not choose to attend, only an optional Women's group (not on any schedule) off the Open Adult unit was available, one hour in the morning and another hour in the afternoon, to those female patients who could leave their unit.</p> <p>B. Record Review</p> <p>Review of "Group Note," "Daily Group Attendance Record," "Daily Nursing Progress Note" and "Interdisciplinary Group Note" forms revealed the following:</p> <ol style="list-style-type: none"> 1. The "Daily Group Attendance Record" on the Open Adult Unit lists the meetings led by Mental Health Technicians (MHTs) and includes Community Meeting, a Recreation/Social event, and a Wrap-Up group. 2. The schedule and "Group Note" sheets for the Open Adult unit show the groups provided which are therapy groups. The schedule shows two groups per day (Recovery and Process) and 	B 125			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 03/14/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 504012	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/20/2019
NAME OF PROVIDER OR SUPPLIER SMOKEY POINT BEHAVIORAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 3955 156TH STREET NORTHEAST MARYSVILLE, WA 98271		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
B 125	<p>Continued From page 57</p> <p>a Recreational Therapy group twice a week (Music Therapy and Yoga). Group Notes reflected these groups. No other groups were available to the patients, and no individual therapy was provided. (For the frequency that sample Patient A1, a patient on the Open Adult unit, attended groups in a one week period, see Section I above.)</p> <p>C. Observations</p> <p>Groups were held in the dayrooms of the units, with many other unscheduled events occurring simultaneously, making it difficult for the group sessions to have structure, or confidentiality for patients who chose to attend:</p> <p>1. The Process Group was observed on 2/18/19 at 1:30 p.m. on the Open Adult Unit. The census on the unit 2/18/19 was 28. The group was held in the large dayroom, immediately adjacent to the nurses' station, and open to the hall that leads to patient rooms, and adjacent to the door through which new admissions come. The pay phone was also in this area. The nurses' station was an open station, with a low counter separating it from the day room, and a lower half door as the connection between the nurses, station and the dayroom area. At the beginning of the group, there were six patients in the group, which was set up as a small semi-circle at one side of the dayroom. Eventually, two more patients came and sat down. Therefore, twenty patients were not present at this modality. At this time, two patients were sitting at a table immediately behind the group, eating lunch and chatting to each other loudly; a new admission was wheeled in on a gurney and stayed in the dayroom/hallway area while being initially admitted: a blood pressure apparatus and a weight scale were wheeled</p>	B 125			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 03/14/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 504012	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/20/2019
NAME OF PROVIDER OR SUPPLIER SMOKEY POINT BEHAVIORAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 3955 156TH STREET NORTHEAST MARYSVILLE, WA 98271		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
B 125	<p>Continued From page 58</p> <p>through the dayroom area to use with the newly admitted patient. Another patient who did not choose to be in the group attempted to use the pay phone and was finally redirected away from the phone by staff. That patient then went to the nurses' station counter and clapped his/her hands very loudly, which was another distraction to the group. The staff in the nurses' station area were talking loudly, occasionally laughing, and opening and slamming the half-door repeatedly. The group leader, who was standing no more than six feet from the group participants, at one point said she could not hear what the participants were saying. No one attempted to contain the noise, except for the staff member who distracted the patient from using the pay phone.</p> <p>2. On 2/19/19 during observation of the morning Community Meeting at 9:30 a.m. on the Open Adult unit, the MHT who conducted the meeting read from the hospital rules with which patients needed to be familiar. She stated that there were no "individual" therapy sessions available to patients, and they should attend groups. There were 14 patients attending the session (census was 32). Four patients walked through the area but did not participate. Of three sample patients from the unit (A1, A2, and A3), only Patient A1 was in the dayroom and s/he was sitting at a table eating breakfast, not attending to the meeting. Eventually, 21 patients were seen in the day area during the meeting time, but the additional seven were not attending to the meeting, but walking around or sitting away from the group outside of the hearing range of the group. The other seven patients out of the census of 28 were not present. Review of the ward rounds sheet showed those seven were in their rooms, not attending, although the MHT stated at the meeting that patient room doors would be locked between 8:00</p>	B 125			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 03/14/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 504012	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/20/2019
NAME OF PROVIDER OR SUPPLIER SMOKEY POINT BEHAVIORAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 3955 156TH STREET NORTHEAST MARYSVILLE, WA 98271		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
B 125	<p>Continued From page 59</p> <p>a.m. and 9:00 p.m. to encourage participation in the programs offered.</p> <p>3. Observation of the Recovery Group at 10:30 a.m. on 2/19/19, also in the dayroom of the Open Adult Unit, revealed between 11 and 14 patients in the group at any one time. The census was 32, so at least 18 patients were not participating. Many were noted on the rounds sheet to be in their rooms sleeping. The noise and activity level outside the group in the rest of the dayroom and the adjacent nurses' station was similar to that noted above (although no patient was being admitted.)</p> <p>III. Ensure adequate integration of the Women's Program into the active treatment program of patients in the facility. The Women's Group was not on the Program schedule of the units, and patients were told about it via a flyer on admission. This program was not on any patient's treatment plan, and therefore no individualized goals for patients who choose to attend the sessions are specified. Female patients on the Open Adult unit who were not restricted could choose these groups at their own discretion rather than attend other groups on the units. Patients from other units could only attend if there was a medical staff order. Failure to integrate this program can permit patients to attend no groups since they are not assigned to any, attend some groups at their discretion, and move from one type of group to another without continuity, thereby potentially delaying progress in treatment and discharge.</p> <p>Findings Include:</p> <p>A. Record Review</p>	B 125			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 03/14/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 504012	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/20/2019
NAME OF PROVIDER OR SUPPLIER SMOKEY POINT BEHAVIORAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 3955 156TH STREET NORTHEAST MARYSVILLE, WA 98271		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
B 125	<p>Continued From page 60</p> <p>1. Review of the schedules on the Open Adult, Transitional Care, and Intensive Care units reveals no mention of the Women's Group on the unit schedules.</p> <p>2. Review of sample patient records for four (4) of four (4) female patients (unnamed to protect identity) revealed that the Master Treatment Plans and updates did not mention the Women's Program as a therapeutic modality. Group notes for one sample patient (unnamed to protect identity) revealed there are three groups each day as part of the Women's Program: a 10:30 a.m. Education group, an 11:00 a.m. Process Group, and a 1:30 p.m. "CBT/DBT" group. All three groups had the same Short Term Goals preprinted on the sheets, and were the same every day and every group type: "Pt will be able to participate in group therapy and be socially appropriate. Pt will be able to verbalize their [sic] needs, feelings, symptoms, and identify their [sic] triggers. Pt will be able to utilize coping skills to improve their [sic] symptoms and mood. Pt will be able to identify their [sic] strengths rather than focus on their [sic] weaknesses. Pt will demonstrate a reduction of their [sic] symptoms and improvement in their mood and overall mental health."</p> <p>B. Observation</p> <p>Observation of the Women's Group on 2/19/19 at 1:30 in the special Women's Group room revealed 4 participants, who were discussing self-esteem.</p> <p>C. Interviews</p> <p>1. In an interview on 2/19/19 at 2:30 p.m. with MSW3, who leads the Women's Program, she</p>	B 125			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 03/14/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 504012	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/20/2019
NAME OF PROVIDER OR SUPPLIER SMOKEY POINT BEHAVIORAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 3955 156TH STREET NORTHEAST MARYSVILLE, WA 98271		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
B 125	<p>Continued From page 61</p> <p>stated that the method by which all adult female patients are introduced to the program is via a two-sided sheet titled "Smokey Point Behavioral Hospital Women's Connection Program." She provided a copy of the sheet, which outlined the purpose of the program ("...to assist women in dealing with depression, anxiety, mood dysregulation, and other mental disorders") and describes the treatment modalities used ("Psychology Education and Process Group Therapy" and "Dialectical and Cognitive Behavioral Therapy.")</p> <p>MSW3 stated, "There is no set format to the group sessions, and patients discuss whatever they are interested in." She also noted that she does not go to treatment team meetings, does not review patient charts, and only knows about patients from what they choose to discuss in the group. Her only communication with the treatment teams was via the Group Note Comments she documented for placement in the patients' records. She stated that every day before groups, she goes around the Open Adult unit, reminding women patients about the group; she does not do this on the other units, because those patients can only come to the group with a medical staff order, since the group is outside the locked units on which those patients are housed. Although the patient attendance on the day of the observation was only four, MSW3 stated she believes the attendance is usually "7-10" patients.</p> <p>2. In an interview with a female patient (unnamed to protect her identity), on 2/19/19 at 4:00 p.m., the patient, who has been in the hospital since 12/21/18, stated she did not know about a Women's Group.</p>	B 125			
B 130	<p>RECORDING PROGRESS</p> <p>CFR(s): 482.61(d)</p>	B 130			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 03/14/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 504012	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/20/2019
NAME OF PROVIDER OR SUPPLIER SMOKEY POINT BEHAVIORAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 3955 156TH STREET NORTHEAST MARYSVILLE, WA 98271		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
B 130	<p>Continued From page 62</p> <p>The frequency of progress notes is determined by the condition of the patient but must be recorded at least weekly for the first 2 months and at least once a month thereafter.</p> <p>This Standard is not met as evidenced by: Based on record review, document review and interview, the facility failed to ensure that social workers wrote progress notes that contained information which specifically addressed patient progress or lack of progress towards treatment goals and discharge planning with the frequency required for eight (8) of eight (8) active sample patients (A1, A2, A3, A4, A5, A6, A7, and A8). This failure impeded the treatment team's ability to evaluate the patient's response to treatment and modify plans as needed.</p> <p>Findings include:</p> <p>A. Record Review</p> <p>1. The progress notes written by social workers contained in group treatment notes and the medical record were reviewed for the following patients (dates of admission in parentheses): A1 (2/1/19), A2 (12/21/18), A3 (1/21/19), A4 (1/11/19), A5 (2/2/19), A6 (12/6/18), A7 (1/10/19), and A8 (12/26/19). The review of progress notes from 2/10/19 through 2/18/19 revealed that social work progress notes were not recorded at the required frequency of weekly for the first two months and monthly thereafter. Documentation by social workers failed to reflect a report of the patient's progress or lack of progress toward treatment goals identified in the Master Treatment Plans (MTP).</p>	B 130			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 03/14/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 504012	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/20/2019
NAME OF PROVIDER OR SUPPLIER SMOKEY POINT BEHAVIORAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 3955 156TH STREET NORTHEAST MARYSVILLE, WA 98271		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
B 130	<p>Continued From page 63</p> <p>2. Social work staff documented progress notes on a form titled, "Group Note." The facility's therapists reportedly used this form to record group attendance and also the patients' progress toward treatment goals identified on the MTPs. This form contained a section titled "Summary" which included a short-term goal and had the following three choices to check: "Pt made progress with goal(s) this session." "Pt made partial progress with goal(s) this session." "Pt did not make progress with goal(s) this session." The facility staff was asked to submit the Group Note Forms from 2/10/19 through 2/18/19. The review of the progress notes written by social workers included the following findings:</p> <p>a. The facility staff submitted no social worker group notes for Patient A5 for this period. Therefore, there was no documentation by social workers regarding this patient's progress or lack of progress toward treatment goals identified in the MTP dated 2/15/19.</p> <p>b. For Patient A6, two social work group notes (2/12/19 and 2/13/19) were found. The group note form, dated 2/13/19, had a short-term goal (STG) of, "Patient will learn a grounding technique to add to their therapeutic toolbox" under the section titled "Summary," and the social worker checked "Pt [Patient] Made progress toward short term goal." This STG was not included in the MTP dated 12/8/18. Therefore, documentation by the social workers failed to reflect the patient's progress or lack of progress toward goals identified in the MTP dated 12/8/18.</p> <p>c. For Patient A7, one social work group note form was found. This form, dated 2/18/18, did not include an STG under the section titled "Summary: Specify patient response to group</p>	B 130			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 03/14/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 504012	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/20/2019
NAME OF PROVIDER OR SUPPLIER SMOKEY POINT BEHAVIORAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 3955 156TH STREET NORTHEAST MARYSVILLE, WA 98271		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
B 130	<p>Continued From page 64</p> <p>content," but checked "Pt made progress with goal(s) this session." This documentation was a progress note recorded for the current group sessions, not for the overall progress or lack of progress related to the treatment goals identified in the MTP. There was no documentation by the social worker during this period that reflected the patient's progress or lack of progress toward those goals identified in the MTP dated 1/11/19.</p> <p>d. For Patient A8, three group note forms were submitted. These forms showed the following information showing no progress or lack of progress toward treatment goals identified in the MTPs:</p> <p>The social work group note, dated 2/10/19, had a short-term goal (STG) of, "To change our thoughts in order to change our behavior" under the section titled "Summary" and the social worker checked "Pt [Patient] Made progress toward short term goal." This goal was not identified in the MTP.</p> <p>The group note, dated 2/14/19, had a short-term goal (STG) of, "learning 1-2 relaxation techniques to cope with stress" under the section titled "Summary" and the social worker did not check any of the three choices regarding progress. The group note, dated 2/15/19, had a short-term goal (STG) of, "learning 1-2 ways to express self, and increase self-esteem" under the section titled "Summary" and the social worker checked "Did not make any progress toward short term goal." These STGs were not included in MTP dated 12/28/18. Therefore, documentation by the social worker during this period failed to reflect the patient's progress or lack of progress toward goals identified in the MTP.</p>	B 130			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 03/14/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 504012	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/20/2019
NAME OF PROVIDER OR SUPPLIER SMOKEY POINT BEHAVIORAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 3955 156TH STREET NORTHEAST MARYSVILLE, WA 98271		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
B 130	Continued From page 65 3. The STGs included on the "Group Note" was not included on the treatment plan. Therefore, it was difficult to determine if the checked progress was related to those goals in the MTPs or just the current social work group session. 4. A review of the medical record revealed there were few notes related to discharge planning found in the medical record. A few notes were found regarding contacts received and made but no recorded sessions with patients regarding discharge planning. B. Interview During a review of the medical records on 2/20/19 at approximately 11:30 a.m., the surveyor identified the lack of social worker progress notes. During a discussion of these notes, a corporate staff stated that the progress notes were supposed to be included on the group note forms. When comparing the goal statement on the group note and those statements in the MTP, she agreed that they were different.	B 130			
B 136	SPECIAL STAFF REQS FOR PSYCH HOSPITALS CFR(s): 482.62 The hospital must have adequate numbers of qualified professional and supportive staff to evaluate patients, formulate written, individualized comprehensive treatment plans, provide active treatment measures and engage in discharge planning. This Condition is not met as evidenced by: Based on observation, document review, and interview, the facility failed to ensure an adequate number of registered nurses and activity	B 136			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 03/14/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 504012	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/20/2019
NAME OF PROVIDER OR SUPPLIER SMOKEY POINT BEHAVIORAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 3955 156TH STREET NORTHEAST MARYSVILLE, WA 98271		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
B 136	Continued From page 66 therapists to provide on-going active treatment to the patient population served. Specifically, the facility failed to: I. Provide an adequate number of Registered Nurses (RNs) to provide and document active treatment interventions, supervise paraprofessional staff, and monitor patients, especially on the Open Adult and Transitional Care Units. The facility's staffing of RNs results in the lack of active treatment provided by registered nurses and limited direction and supervision of paraprofessional staff in the provision of psychiatric nursing care. (Refer to B150). II. Employ a sufficient number of activity therapy staff to provide activity therapy sessions seven days per week on evenings and weekends for 8 of 8 active sample patients (A1, A2, A3, A4, A5, A6, A7, and A8) on the five inpatient units. This failure results in patients not receiving a full complement of therapies and individualized and goal-directed active treatment. (Refer to B158).	B 136			
B 144	MEDICAL STAFF CFR(s): 482.62(b)(2) The director must monitor and evaluate the quality and appropriateness of services and treatment provided by the medical staff. This Standard is not met as evidenced by: Based on record review and interview the Medical Director failed to assure adequate input from medical staff in the development of assessments and treatment plans for eight (8) of eight (8) active sample patients (A1, A2, A3, A4, A5, A6, A7, and A8). This failure prevents patients from having all the necessary input from the treating	B 144			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 03/14/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 504012	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/20/2019
NAME OF PROVIDER OR SUPPLIER SMOKEY POINT BEHAVIORAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 3955 156TH STREET NORTHEAST MARYSVILLE, WA 98271		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
B 144	<p>Continued From page 67</p> <p>members of the medical staff in the development of individualized treatment to assure successful discharge.</p> <p>Findings include:</p> <p>A. Record Review</p> <p>1. Review of the records revealed that the History and Physical (H&P) examinations were incomplete for eight (8) of eight (8) sample patients (A1, A2, A3, A4, A5, A6, A7, and A8). In two instances (patients A2 and A5), the H&P exams were not completed on admission. In four of eight records, the area of reflex exam in the neurologic exam was not completed (A1, A4, A6, and A8). In none of the records was a complete screening neurologic exam performed (A1, A2, A3, A4, A5, A6, A7, and A8). (Refer to B109).</p> <p>2. Review of the psychiatric assessments revealed that an adequate assessment of memory was not performed for seven (7) of eight (8) patients (A1, A2, A4, A5, A6, A7, and A8). In one assessment (A2), dated 12/21/19, the assessment was performed by a nurse practitioner, and although the form indicated the document required a physician review and signature, that was not done. (Refer to B116).</p> <p>3. Review of Master Treatment Plans and updates revealed that medical staff members were frequently signing the forms on dates other than other staff members who took part in developing the plans, or not signing them at all for four (4) of eight (8) active sample patients (A1, A2, A3, and A4). (Refer to B118).</p> <p>B. Interview</p>	B 144			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 03/14/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 504012	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/20/2019
NAME OF PROVIDER OR SUPPLIER SMOKEY POINT BEHAVIORAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 3955 156TH STREET NORTHEAST MARYSVILLE, WA 98271		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
B 144	Continued From page 68 In an interview with the Medical Director on 2/19/19 at 12:30 p.m., he stated that the medical staff did peer reviews, but that there was no systematic review of any areas of medical staff involvement in patient care.	B 144			
B 148	NURSING SERVICES CFR(s): 482.62(d)(1) The director must demonstrate competence to participate in interdisciplinary formulation of individual treatment plans; to give skilled nursing care and therapy; and to direct, monitor, and evaluate the nursing care furnished. This Standard is not met as evidenced by: Based on observation, record review, interview, and policy review, the Director of Nursing (DON) failed to monitor psychiatric nursing care, provide adequate oversight, and take corrective actions to ensure quality nursing services. Specifically, the DON failed to: I. Ensure that Master Treatment Plans (MTPs) contained individualized nursing interventions to address specific psychiatric treatment needs of eight (8) of eight (8) active sample patients (A1, A2, A3, A4, A5, A6, A7, and A8). Specifically, MTPs failed to include active treatment interventions based on presenting psychiatric symptoms resulting in hospitalization. Instead, the interventions listed on the preprinted problem sheets were generic, routine registered nurse job duties, and did not consistently state a method of delivery, or a focus of treatment. These failures result in a lack of guidance for nursing staff to provide coordinated and individualized active treatment, potentially delaying patient improvement and discharge from the hospital. (Refer to B122).	B 148			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 03/14/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 504012	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/20/2019
NAME OF PROVIDER OR SUPPLIER SMOKEY POINT BEHAVIORAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 3955 156TH STREET NORTHEAST MARYSVILLE, WA 98271		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
B 148	<p>Continued From page 69</p> <p>II. Ensure detailed treatment notes regarding active treatment interventions from the Master Treatment Plan and for alternative interventions when required were documented by registered nurses (RN) for four (4) of eight (8) active sample patients (A5, A6, A7, and A8) Specifically, there was no documentation at all that showed nursing interventions identified on MTPs were implemented. This failure hinders the treatment team in determining the patients' response to active treatment interventions, evaluating if there were measurable changes in the patients' condition and revising the treatment plan when the patient did not respond to treatment interventions. (Refer to B124).</p> <p>III. Ensure a sufficient number of Registered Nurses (RNs) to provide and document active treatment interventions, supervise paraprofessional staff, and monitor patients, especially on the Open Adult and Transitional Care Units. The facility's staffing of RNs results in the lack of active treatment provided by registered nurses and limited direction and supervision of paraprofessional staff in the provision of psychiatric nursing care. (Refer to B150).</p> <p>IV. Ensure a comprehensive fall prevention program that included an assessment and reassessment for falls and a protocol for preventing falls. Specifically, the facility had not implemented a comprehensive fall prevention policy that included initial assessment and screening of fall risk at admission, and ongoing reassessments after admission. The facility also failed to develop and implement individualized fall intervention treatment plans. This failure potentially results in placing vulnerable patients at</p>	B 148			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 03/14/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 504012	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/20/2019
NAME OF PROVIDER OR SUPPLIER SMOKEY POINT BEHAVIORAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 3955 156TH STREET NORTHEAST MARYSVILLE, WA 98271		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
B 148	<p>Continued From page 70 risk of falls during their hospitalization.</p> <p>Findings include:</p> <p>A. Record and Policy Review</p> <p>1. Patient A6 was admitted on 12/06/18. The patient's MTP, signed 12/8/18 had a problem of "Risk for Falls as Evidenced By: Seizure D/O [Disorder]." The preprinted form contained generalized goals and non-specific interventions. Since there was no assessment related to the level of risk (high, low, or moderate) with associated interventions, this preprinted form was not individualized to the assessed needs of the patient.</p> <p>2. Patient E1 was admitted on 3/19/18 and experienced a fall at the facility on 6/18/18. The fall risk assessment completed on admission showed that the patient had a score of 5, although it did not include the assessments used to determine this level of risk. According to the assessment, "A score of 5 or above indicates patient is at a potential risk for falls." The form had "Initiate Fall Precautions" on the form. There were no instructions regarding actions to be taken to initiate the precautions.</p> <p>3. A review of the facility policy for fall prevention revealed two policies in effect both dated "5/17" and one titled "Patient Safety Precautions" and the other titled "Fall Prevention Program Guidelines." These policies had the following requirements:</p> <p>a. The policy titled "Patient Safety Precautions" stipulated that "The Registered Nurse utilizes the Fall Risk Assessment Form to assess the patient for levels of fall risk upon admission, and every</p>	B 148			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 03/14/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 504012	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/20/2019
NAME OF PROVIDER OR SUPPLIER SMOKEY POINT BEHAVIORAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 3955 156TH STREET NORTHEAST MARYSVILLE, WA 98271		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
B 148	<p>Continued From page 71</p> <p>shift. Upon completion of assessment, the RN assigns the patient to a level ..." There was no risk assessment form completed for this patient after admission. There were no interventions designated for the levels of fall risk. This policy contained no requirements for training to ensure staff awareness and ongoing alertness of the potential fall risk during hospitalization.</p> <p>b. The policy titled "Fall Prevention Program Guidelines" stipulated,</p> <p>"1. Admission - a. Assess patients at risk for falls on admission using (1) the Morse Fall Scale for adults. (2) the Humpty Dumpty Scale for children. b. The RN will place the patient on Fall Precautions according to the resulting score on the Fall Scale.</p> <p>2. During Hospitalization - a. Continue to assess the patient for changes in his/her condition and treatment that puts patient at risk for falls and repeat the fall scale, after each fall and as indicated ... The treatment plan will identify any and all individualized interventions to prevent falls ..."</p> <p>B. During a discussion on 2/20/19 at approximately 11:00 a.m., Program Manager 1 stated that the Morse Fall Scale had not been implemented. She also said that there was no assessment form completed after admission either every shift or after a fall.</p>	B 148			
B 150	<p>NURSING SERVICES</p> <p>CFR(s): 482.62(d)(2)</p> <p>There must be adequate numbers of registered nurses, licensed practical nurses, and mental health workers to provide the nursing care necessary under each patient's active treatment</p>	B 150			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 03/14/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 504012	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/20/2019
NAME OF PROVIDER OR SUPPLIER SMOKEY POINT BEHAVIORAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 3955 156TH STREET NORTHEAST MARYSVILLE, WA 98271		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
B 150	<p>Continued From page 72 program.</p> <p>This Standard is not met as evidenced by: Based on observation, document review, and interview, the facility failed to provide an adequate number of Registered Nurses (RNs) to provide and document active treatment interventions, supervise paraprofessional staff, and monitor patients, especially on the Open Adult and Transitional Care Units (TCU). The facility's staffing of RNs results in the lack of active treatment provided by registered nurses and limited direction and supervision of paraprofessional staff in the provision of psychiatric nursing care.</p> <p>Findings include:</p> <p>I. Transitional Care Unit</p> <p>A. Observations</p> <p>1. Observations occurred on the Transition Unit on 2/18/19 from 11:20 a.m. to 12:10 p.m. The census was 22 patients and on 2/19/18 from 10:30 to 11:00 a.m. The census was 23 patients. During these observations, the registered nurse (RN) rarely left the nursing station. The charge registered Nurses (RN) duties included, admitting patients, discharging patients, transferring patients, completing paperwork associated with admissions and discharges and physicians orders, answering phones. During the entrance meeting on 2/18/19 at 9:21 a.m., the facility staff reported that psychiatrists treated patients on more than one unit. Therefore, this required the RN to potentially attend multiple treatment planning sessions throughout the day. These</p>	B 150			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 03/14/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 504012	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/20/2019
NAME OF PROVIDER OR SUPPLIER SMOKEY POINT BEHAVIORAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 3955 156TH STREET NORTHEAST MARYSVILLE, WA 98271		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
B 150	<p>Continued From page 73</p> <p>work assignment represented an extremely heavy workload for one RN.</p> <p>2. The Licensed Practical Nurse (LPN) duties were administering medications to 22 patients (most had multiple medications), giving treatments, transcribing physicians' orders, and calling to get clarification of these orders. Both nurses remained in the nursing stations most of the time. While RNs stayed in the nursing station, there was limited contact with patients to provide psychiatric nursing care. The two Mental Health Technicians (MHT) received limited supervision in providing care and monitoring patients.</p> <p>B. Document Review</p> <p>1. An analysis of the staffing data for the TCU on the day of the survey 2/18/9 revealed the unit had a census of 22 patients with the following staffing:</p> <p>7 a.m. to 7 p.m. Shift: One RN, One LPN, and 2 MHTs.</p> <p>7 p.m. to 7 a.m. Shift: One RN, One LPN, and 2 MHTs. No nurse supervisor was available to provide coverage for meal breaks.</p> <p>2. Review of a "Nursing Needs Assessment" Form completed on 2/18/19 for the TCU revealed a high acuity level and the following patient care needs:</p> <p>a. Patients requiring special treatment interventions included: One patient on seizure precaution, one patient requiring Diabetic Checks, and one patient requiring skin care treatments.</p> <p>b. One patient was classified as being potentially</p>	B 150			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 03/14/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 504012	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/20/2019
NAME OF PROVIDER OR SUPPLIER SMOKEY POINT BEHAVIORAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 3955 156TH STREET NORTHEAST MARYSVILLE, WA 98271		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
B 150	<p>Continued From page 74</p> <p>assaultive. Two patients were classified as having a low risk for suicide and required some protection against impulses. Thirteen (13) patients were experiencing active hallucinations/delusions and were in potential jeopardy due to these disturbances in thought processes.</p> <p>c. Special Status patients included: Four (4) patients were on fall precautions. One patient was on assault precaution. One patient was elopement precautions. Five (5) patients were classified as being constantly demanding of staff time (e.g., requests and interruptions).</p> <p>3. The Nursing Needs Assessment data also showed that the unit had an average of eight (8) transfers per week on the day shift and two (2) on the night shift and an average of six (6) discharges per week.</p> <p>4. A review of the staffing data for one week from 2/10/19 and 2/16/19 revealed the following staffing pattern with census ranging from 21 - 26 patients:</p> <p>a. 7 a.m. to 7 p.m. Shifts: Two licensed staff (one RN and one LPN) for three out of 7 shifts; one RN for two of seven shifts; two RNs for one shift; and three RNs for one of seven shifts. There were two MHTs for six out of seven shifts and one MHT for one of seven shifts.</p> <p>b. 7 p.m. to 7 a.m. Shifts: Two licensed staff (one RN and one LPN) for five out of seven shifts; two RNs for one shift; and one RN and two LPNs for one shift. There were two MHTs for three out of seven shifts; one MHT for three out of seven shifts; and zero MHT for one shift.</p>	B 150			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 03/14/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 504012	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/20/2019
NAME OF PROVIDER OR SUPPLIER SMOKEY POINT BEHAVIORAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 3955 156TH STREET NORTHEAST MARYSVILLE, WA 98271		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
B 150	<p>Continued From page 75</p> <p>5. Active treatment interventions assigned on the Master Treatment Plan and listed on the unit schedules (Medication education and Healthy Living Groups) were not recorded as being implemented. None of the active samples had treatment notes documented for any of the interventions on the MTPs. (Refer to B124).</p> <p>C. Interviews</p> <p>1. In an interview on 2/19/19 at 11:10 a.m., when asked about taking meal breaks, RN1 stated, "No, not often."</p> <p>2. In an interview on 2/20/19 at 9:50 a.m., with review of the "Direct Nursing Staffing Form" for the first day of the survey (2/18/19) and a week period (2/10/16 to 2/16/19), the Director of Nursing did not dispute the findings that there was insufficient RN staff to provide active interventions on the MTPs. She stated that she had to sometime work on the units to ensure at least one RN on each unit.</p> <p>II. Adult Unit</p> <p>A. Observations</p> <p>Observations occurred on the Open Adult Unit on 2/19/19 at 9:30 a.m. and 10:30 a.m. The census was 32 patients. During these observations, the registered nurse (RN) rarely left the nursing station. The charge Registered Nurses (RN) duties included admitting patients, discharging patients, transferring patients, completing paperwork associated with admissions and discharges and physicians orders, and answering phones. The Charge RN was also required to attend treatment planning meetings. Since multiple psychiatrists treated patients on the unit,</p>	B 150			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 03/14/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 504012	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/20/2019
NAME OF PROVIDER OR SUPPLIER SMOKEY POINT BEHAVIORAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 3955 156TH STREET NORTHEAST MARYSVILLE, WA 98271		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
B 150	<p>Continued From page 76</p> <p>this potentially required the RN to attend multiple treatment planning sessions. These work assignments represented an extremely heavy workload for one RN.</p> <p>B. Document Review</p> <p>1. A review of the staffing data for the Adult Unit on the day of the survey 2/18/9 revealed the unit had a census of 27 patients with the following staffing:</p> <p>7 a.m. to 7 p.m. Shift: One RN, One LPN, and Three MHTs.</p> <p>7 p.m. to 7 a.m. Shift: Two RN, One LPN, and One MHT. No nurse supervisor was available to provide coverage for meal breaks on this shift.</p> <p>2. Review of a "Nursing Needs Assessment" Form completed on 2/18/19 for the Mental Health Unit revealed a high acuity level and included the following patient care needs:</p> <p>a. Patient requiring special treatment interventions included: One patient requiring Diabetic Checks; one patient requiring catheter care; one patient on detox protocol; one patient requiring colostomy care; and 21 patients requiring escort off the unit to meals.</p> <p>b. Two patients were classified as having a low risk for suicide and required some protection against impulses. Two patients were classified as having a high potential for self-injury and required close observation.</p> <p>c. Special Status patients included: Three (3) patients were admitted within the last 48 hours; 12 patients were classified as being constantly</p>	B 150			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 03/14/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 504012	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/20/2019
NAME OF PROVIDER OR SUPPLIER SMOKEY POINT BEHAVIORAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 3955 156TH STREET NORTHEAST MARYSVILLE, WA 98271		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
B 150	<p>Continued From page 77</p> <p>demanding of staff time (e.g., requests and interruptions).</p> <p>3. A review of the staffing data for one week from 2/10/19 and 2/16/19 revealed the following staffing pattern with census ranging from 22 - 26 patients:</p> <p>a. 7 a.m. to 7 p.m. Shift: Two licensed staff (one RN, one LPN) for four out of seven shifts; One licensed staff (RN) for two out of seven shifts, and two RNs for one of seven shifts. There were two MHTs all seven shifts.</p> <p>b. 7 p.m. to 7 a.m. Shift: Two licensed staff (one RN and one LPN) for five out of seven shifts and one licensed staff (RN) for two shifts. There were two (2) MHTs for four (4) out of seven (7) shifts and two (2) MHTs for three (3) out of seven (7) shifts.</p> <p>III. Additional Information</p> <p>1. The "Nursing Complement Data" submitted showed that the facility had a total of 7.6 FTEs for RN assigned to the 7p - 7a shift. This number of FTEs was not sufficient RN coverage for the five (5) units. There was not an adequate number of RN FTEs to provide for days off, vacation and sick time, or staff training. The data showed four RN vacancies on the 7p - 7a shift.</p> <p>2. The Director of Nursing, in addition to her administrative responsibilities, occasionally had to provide RN coverage due to insufficient RN staff. The DON confirmed she provided coverage on 2/5/19 on the Open Adult Unit. The "Direct Nursing Staffing Form" showed that she provided RN coverage on the Adolescent Unit on 2/18/19 on the 7a - 7p shift.</p>	B 150			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 03/14/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 504012	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/20/2019
NAME OF PROVIDER OR SUPPLIER SMOKEY POINT BEHAVIORAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 3955 156TH STREET NORTHEAST MARYSVILLE, WA 98271		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
B 150	Continued From page 78 3. The staffing on the Military Unit on 2/12/19 had a one (1) RN and no other staff on the 7a- 7p shift. 4. The Open Adult Unit had a census of 32 on 2/19/19. All of these patients were on the unit until bedtime when four (4) patients were housed on a closed unit on the same floor with one staff.	B 150			
B 158	THERAPEUTIC ACTIVITIES CFR(s): 482.62(g)(2) The number of qualified therapists, support personnel, and consultants must be adequate to provide comprehensive therapeutic activities consistent with each patient's active treatment program. This Standard is not met as evidenced by: Based on document review and interview, the facility failed to employ a sufficient number of activity therapy staff to provide activity therapy sessions seven days per week on evenings and weekends for 8 of 8 active sample patients (A1, A2, A3, A4, A5, A6, A7, and A8) on the five inpatient units. This failure results in patients not receiving a full complement of therapies and not receiving individualized and goal-directed active treatment. Findings include: A. Document Review 1. A review of the unit schedules revealed that two patient units, Transition Care (TCU), and Intensive Units (ICU) had activity therapy available only six days per week and Open Adult Unit had activity therapy two days per week. The	B 158			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 03/14/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 504012	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/20/2019
NAME OF PROVIDER OR SUPPLIER SMOKEY POINT BEHAVIORAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 3955 156TH STREET NORTHEAST MARYSVILLE, WA 98271		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
B 158	<p>Continued From page 79</p> <p>facility did not have activity therapy staff assigned on evenings and weekends after 2:00 p.m. Nursing staff were responsible for diversional activities on the units and in the gymnasium on evenings and weekends.</p> <p>2. A review of the unit schedules showed that all of the units had pet therapy scheduled one day per week. The pet therapist did not document group attendance or group treatment notes.</p> <p>3. The three full-time activity therapists workload included providing groups for an average daily census of 84 patients, completing assessments for an average of five newly admitted patients per week, and documenting group treatment and progress notes for all patients attend the activity therapy groups and all patients that refuse to participate. In addition, according to the Recreational Therapy Manager, during the interview on 2/10/19 at 9:10 a.m., she was responsible for attending the treatment planning meetings Monday through Friday. These work activities represented an extremely heavy workload for the activity therapy staff.</p> <p>4. The review of the Master Treatment Plans (MTPs) revealed that seven (7) of eight (8) active sample patients (dates plans were signed in parentheses): A1 (2/3/19), A2 (12/21/18), A3 (1/23/19), A5 (2/15/19), A6 (12/8/18), A7 (1/11/19), and A8 (12/28/18) had at least two activity therapy groups assigned daily on their treatments plans. However, the unit schedules showed one group offered two days per week on the Open Adult Unit, and one group offered six days per week on the Transitional Care and Intensive Care Units. The Recreational Therapy Manager confirmed on 2/19/19 at 9:10 a.m. that the facility offered only one group per day on TCU</p>	B 158			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 03/14/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 504012	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/20/2019
NAME OF PROVIDER OR SUPPLIER SMOKEY POINT BEHAVIORAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 3955 156TH STREET NORTHEAST MARYSVILLE, WA 98271		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
B 158	<p>Continued From page 80 and ICU.</p> <p>B. Interviews</p> <p>1. In an interview on 2/18/19 at 11:55 a.m., RT1 stated she was a PRN [per diem] staff and worked approximately two days per week. She noted that she was assigned a unit after she arrived at the hospital. When asked if she reads patients' treatment plans to know their goals and needs, she stated, "I get to know the patients who attend. I don't always have time to read each patient's treatment plan."</p> <p>2. In an interview on 2/18/19 at 3:40 p.m., Patient A6 stated, "We have a lot of downtime. I wish we had more gym [gymnasium] time. Some days we don't get to go to the gym at all."</p> <p>3. In an interview on 2/20/19 at 9:10 a.m., with the Recreational Therapy Manager, the insufficient evenings and weekends therapeutic activities were discussed. She did not dispute the findings and acknowledged that they did not have enough staff to provide active treatment groups seven days per weeks during evening hours and on weekends. She reported a total of three full-time recreational therapists employed, including her, to cover the entire hospital with a bed capacity of 115 patients.</p> <p>4. During the exit conference on 2/20/19 at approximately 2:00 p.m., the CEO agreed with the findings regarding insufficient activity therapists.</p>	B 158			